AT WHAT COST?

HIV AND HUMAN RIGHTS CONSEQUENCES OF THE GLOBAL "WAR ON DRUGS"

OPEN SOCIETY INSTITUTE
Public Health Program

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International Harm Reduction Development Program

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A member of Mexico's Federal Investigative Agency guards people arrested on suspicion of possessing drugs during an antinarcotics operation in Mexico City.

Public Health Program

The Open Society Institute's Public Health Program (PHP) works to advance the health and human rights of marginalized persons by building the capacity of civil society leaders and organizations and advocating for accountability and a strong civil society role in health policy and practice. To advance its mission, the program supports the development and implementation of health-related laws, policies, and practices that are grounded in human rights and evidence. PHP utilizes five core strategies to advance its mission and goals: grantmaking, capacity building, advocacy, strategic convening, and mobilizing and leveraging other funding. PHP's project areas include harm reduction, sexual health and rights, access to essential medicines, mental health, health policy and budget monitoring, palliative care, Roma health, law and health, health media, and engagement with the Global Fund to Fight AIDS, Tuberculosis and Malaria. As of 2009, PHP worked in Central and Eastern Europe, Southern and Eastern Africa, certain countries of South East Asia, and China.

International Harm Reduction Development Program

The International Harm Reduction Development Program (IHRD), part of the Open Society Institute's Public Health Program, works to reduce HIV and other harms related to injecting drug use and to press for policies that reduce stigmatization of illicit drug users and protect their human rights. Since 1995 IHRD has supported more than 200 programs in Central and Eastern Europe and Asia, and bases its activities on the philosophy that people unable or unwilling to abstain from drug use can make positive changes to protect their health and the health of others. Since 2001, IHRD has prioritized advocacy to expand availability and quality of needle exchange, drug dependence treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the participation of people who use drugs and those living with HIV in shaping policies that affect their lives.

Contents

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This volume is dedicated to all those who have lost their lives to the global "War on Drugs," through AIDS, overdose, violence, or other results of stigma, discrimination, and violations of human rights precipitated by harmful drug policies.

Introduction

A decade ago, the member states of the United Nations gathered for a special session of the General Assembly to address the question of how to respond to the world's drug problems. Convened under the motto "A Drug-free World: We Can Do It!" the nations pledged to achieve significant progress toward total elimination of the opium poppy, the coca bush, and the cannabis plant, and to take "appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances."[1] They also agreed to convene another high-level meeting ten years later to assess how these efforts were progressing.

This volume, which focuses on the experiences of people who use drugs and those who work with them, offers a partial answer. While drug control policies have indeed been strengthened in many countries of the world, there is little evidence that they have succeeded in significantly reducing supply of illicit drugs or the numbers of people who use them. Abundantly evident, however—and now acknowledged by the Executive Director of the United Nations Office on Drugs and Crime, as well as virtually every credible independent authority on the subject—is that drug control has had multiple, unintended negative consequences. Whether you are talking about Pakistan or Phnom Penh, Manipur or Moscow, the "war on drugs" has frequently devolved into a war on drug users, resulting in increased incarceration, human rights violations, and disease. After reading the stories contained here of suspected drug users in Indonesia strip-searched on public streets; former drug users in China humiliated in front of their families and friends and hauled in handcuffs to police stations for urine tests; or newly incarcerated drug users in India having their withdrawal symptoms treated by prison authorities with "the stick," the question is not just whether a drug-free world is possible, but how many violations of human dignity and ethical conduct are seen as acceptable in the effort to achieve it. How can drug control conventions aimed at "reducing human suffering"[2] be permitted to excuse so much hardship and humiliation?

Today, and in the next decade, the goal should be to achieve total elimination or significant reduction in these unconscionable abuses committed in the name of drug control.

The costs and scars of the war on drug users are carried on the bodies and minds of those interviewed here. In China, a mother who used drugs for a brief time and stopped still remembers the look on her daughter's face as they were pulled from a line to process papers so her daughter could attend university, and she was ordered by police in front of all the other families to submit to a urine test. In Cambodia, women accused of drug use tell of being rounded up, locked together in former Khmer Rouge torture facilities where they were subjected to beatings and rapes, and denied food or medicines to alleviate the painful symptoms of withdrawal. They were allowed only two bathroom breaks a day, and

A woman watches as a policeman conducts an antinarcotics operation in Mexico City.
Daniel Aguilar/ Reuters

those who defecated on themselves received more beatings. One woman who escaped these tortures vows to never again seek help for addiction. In Karachi, Pakistan, a drug user describes how police beat him and his friends mercilessly, assuming that they were intoxicated and couldn't feel the pain, or forced them to strip in order to beat them on their injection wounds.

Despite the fact that sharing injection equipment is among the most efficient means of HIV transmission and that an estimated 33.4 million people were then living with HIV,[3] the 1998 declarations from the UN's General Assembly Special Session on Drugs did not mention AIDS or include AIDS experts in the proceedings. A decade later, the price of that omission is terribly clear. Outside of Africa, nearly one third of new HIV infections are due to contaminated injection equipment. In Eastern Europe, Central Asia, and much of Southeast Asia and the Southern Cone of Latin America—including countries of such enormous size and geopolitical importance as Russia, China, Ukraine, Malaysia, and Indonesia—injection drug users account for the largest share of those with HIV. Those shaping the global response to drugs in 1998 did not mention the need for programs to provide sterile injection equipment, or the importance of prescribing the essential medicines methadone and buprenorphine that reduce opiate injection and HIV risk. These approaches were omitted from the 1998 declarations despite the multiple studies showing that they in no way encourage new drug use, but are effective to reduce risk of blood-borne infections, reduce illicit drug use, and are associated with improved family function, adherence to HIV treatment, and linkages to other kinds of care.

As these chapters make clear, such lifesaving HIV prevention approaches, often referred to collectively as harm reduction, have been not only ignored but impeded by global drug control efforts. In Burma, opium shortages resulting from drug seizures have led many to turn to drug injecting so that they can get more for their money; harm reduction services, such as needle exchange programs, however, are largely unavailable. In Vietnam, tens of thousands of drug users are interned for years in compulsory treatment centers whose primary mode of "treatment" is forced labor for ten or more hours a day at below market wages; those who fail to meet their quotas are beaten or locked in small isolation cells for weeks. Despite high levels of HIV infection (internees are tested, though not told the result) and continued drug use in the centers, antiretroviral treatment and sterile injection equipment are almost always unavailable. In Manipur, India, as in many places that refuse for ideological reasons to provide sterile injection equipment in prisons, as many as 30 inmates share a single syringe. In Russia, where more than 80 percent of the nation's cumulative one million HIV infections have been due to injecting drug use, and where 80 percent of those infected are under age 30, the essential medications methadone and buprenorphine are illegal. In Brazil, though harm reduction approaches are permitted by law, the "law of the streets" says otherwise: police use possession of sterile syringes as evidence to arrest people on drug charges, and heavily armed drug raids into urban slums breed distrust of outsiders, including public health workers.

In addition to measuring hectares of opium eradicated or coca fields fumigated, it is clearly time for the United Nations to engage in another calculus: the measure of how many people will die in the name of zero-tolerance policies that require drug users to be abstinent before they are considered human or worthy of human rights. Considered together, the accounts in these pages make it clear that harm reduction must be reconceptualized to include not only measures to prevent the spread of blood-borne illness, but also to reduce the suffering and pain caused by bad drug policies.

Overview

Section I: A War on Drug Users: Police Abuse in the Name of Drug Control

Police practices violate drug users' human rights and hinder their access to health care and harm reduction services.

This book begins with four case studies that examine how policing practices directly impact the lives of people who use drugs. Though the settings differ, the themes are similar: an approach to drug use that is primarily the responsibility of law enforcement officials rather than health care personnel results in corruption, abuses, and reluctance on the part of drug users to access even the most basic disease prevention services.

In all of the countries featured in this section—Indonesia, Cambodia, China, and India—injection drug use continues to be a major mode of HIV transmission. HIV prevalence among injection drug users is more than 10 percent in all the countries; indeed in Indonesia the proportion of IDUs who are HIV positive is estimated at 42.5 percent.[4] As these chapters make clear, it is not enough to simply institute such services as needle exchange, methadone and buprenorphine, and HIV treatment—these services must exist in an environment in which people who use drugs do not risk police abuse and punishment when attempting to access them. As the recent UN-commissioned report "Redefining AIDS in Asia" points out, HIV prevalence in Asia is still concentrated largely among high-risk groups (sex workers, injection drug users, and men who have sex with men), and in order to prevent a generalized epidemic, governments should focus their attention on prevention and treatment among these specific groups. For such programs to succeed, efforts to reduce stigma and discrimination, and to engage affected individuals, are vital.[5]

In their chapter, Sara L.M. Davis and Agus Triwahyuono describe the findings of a grassroots effort on the part of Jangkar, a network of groups working with people who use drugs in Indonesia, to document police abuses against drug users. Through focus groups, a written survey, and in-depth interviews with drug users and others, the study gathered evidence of how draconian laws and corruption together result in abuses of people who use drugs. Indonesia's restrictive drug legislation includes making it illegal to carry syringes without a prescription. Possession of even small amounts of drugs can result in up to nine years in prison; as there are no clear guidelines for sentencing based on quantity of drugs in possession, judges exercise wide discretion in imposing terms of punishment.

The majority of drug users interviewed reported experiencing physical abuse at the hands of the police, and half reported psychological abuse; people who use drugs detailed how police beat and tortured them in order to elicit confessions for unsolved crimes and to extort bribes. As one person recounted, "They accused me of selling *putaw* [low-grade heroin]. They searched me and my friend. They found nothing. After 30 minutes, three more policemen came…I was beaten up and my toenails were pulled out so that I would admit that I sold *putaw*. It lasted four hours." As Davis and Triwahyuono point out, with people who use drugs facing extortion, arrest and torture, and long prison sentences, it is no surprise that they are driven underground, away from services, and with increased chances of engaging in risky practices, including unsafe sex and needle-sharing.

The next chapter moves away from focus groups and data to firsthand accounts that examine, through five interviews with drug users, the impacts of policies to address drug use in Cambodia. Police there frequently conduct raids to round up drug users and other marginalized groups (including sex workers, elderly homeless people, and street children) in order to "beautify" the streets before public holidays. People who use drugs are forced into compulsory treatment centers that, in reality, offer little in the way of treatment, and may instead endanger the health and life of those interned there. In addition to lack of ade-

A policeman patrols drug users at work in a compulsory drug rehabilitation clinic in China, where people are often used as a source of cheap labor, working long hours and enduring punishments if work quotas aren't met. Reinhard Krause/Reuters

quate food or appropriate medications for alleviating painful drug withdrawal or treating other common medical conditions (including HIV, tuberculosis, and hepatitis C), those interviewed for this chapter report experiencing serious human rights abuses at the hands of guards in so-called treatment centers, including severe beatings and sexual assault.

Recently, police roundups of drug users have again escalated in Cambodia, with the new police chief reportedly pledging in December 2008 to round up all drug users and to build additional treatment centers in which to intern them. Police have stationed themselves between a main drug-using neighborhood and the harm reduction organization where people who use drugs go to obtain clean injection equipment and other health services. As a result, organizations working with drug users have been unable to locate their usual clientele, who have gone into hiding.

Police raids are only one means of social control; regimes of forced drug testing and internment are another. The third chapter looks at China's policy of registration and compulsory urine testing of people who use or who have used drugs. The system is such that when people use their government-issued ID cards—for example to check into a hotel or apply for government documents—their names appear on a web-based registry. Police then arrest them and take them to the police station for compulsory testing that can sometimes take the better part of a day. Besides being humiliating and inconvenient, people forced to submit to the drug tests may experience other kinds of abuse, including unnecessary violence and violations of confidentiality. A single positive urine test can

result in three years of forced confinement, followed by three years of "community treatment" at centers that are really labor camps under a new name. The stories in this chapter tell the experiences of several former drug users arrested and tested while attempting to go about their daily lives. While these experiences take place in China, drug user registries and forced urine testing have similar negative implications in other countries. In Ukraine, being listed on government registries as a drug user can lead to loss of employment, denial of a driver's license, or even loss of custody of children.[6] In Georgia, where police force suspected drug users to take compulsory drug tests, a positive test results in a fine so large that it often obliges people to forgo necessary medical care or, if they can't pay, see their home confiscated to be auctioned off by the government.[7]

The final chapter in this section moves to South Asia to look at Manipur, in northeast India, where a combination of factors—the state is situated near a major center of opium production and also has a strong military and paramilitary presence—produce a situation where drug use is widespread, and responses to it are primarily punitive in nature. Through focus group discussions and in-depth interviews, the authors, Chakrapani and Kumar, examine drug users' interactions with police and military forces, and the impacts of those interactions on access to health programs.

Chakrapani and Kumar find that people who use drugs have a high likelihood of being stopped and searched, ostensibly due to security concerns related to the insurgency. In reality, they may be an easy target from which police and military forces can extort bribes. Respondents reported that searches are more common near drug hotspots, or for people with visible injection scars. Police activities had a direct impact on drug users' ability to practice harm reduction and access health services: people who use drugs were afraid to carry clean syringes, and reported injecting in a hurried manner or in less safe areas on the body to avoid detection by police. Respondents said that police often staked out drop-in centers and needle exchange programs to arrest drug users as they exited. Furthermore, police harass and hamper the work of peer educators and outreach staff. As described in other chapters in this section, people who use drugs had to pay regular "taxes" to police in order to avoid arrest; they also reported the ability to bribe their way out of arrests or to obtain lighter sentences. Drug users who are not able to pay their way out of prison find themselves in a situation where drugs continue to be available, but clean injecting equipment is not, resulting in up to 30 inmates sharing one syringe. Sex workers who use drugs face particular harassment and abuse.

The negative health implications of these police tactics are clear: people who use drugs are afraid to engage with harm reduction services, they are more likely to share used syringes, sex workers who use drugs have to take more clients in order to make up the money lost to police bribes, and heavy reliance on incarceration means that increasing numbers of people are at risk of HIV infection and other blood-borne viruses.

Residents of the Rocinha slum in Rio De Janeiro, Brazil pass by heavily armed antinarcotics officers during a search for drug traffickers. Almeida/AFP/Getty Images

Section II: Superpower Influence: The Export of Russian and American Approaches

Russia and the United States pressure their neighbors to adopt their hard-line approaches to drugs.

The second section of this book looks specifically at the influence of two superpowers—the United States and Russia—on the drug policies of neighboring countries. Since the fall of the Soviet Union, Russia has sought to influence its neighbors to introduce drug legislation as strict as its own. While citing obligations under the UN drug control conventions, Russia's drug laws have often gone beyond the conventions. The chapter by the Canadian HIV/AIDS Legal Network looks specifically at four member countries of the Commonwealth of Independent States (CIS), and examines the extent to which they have adopted a CIS model law on drugs (largely informed by Russia) or the drug laws of Russia itself. Both Russia's drug legislation and the CIS model law share common features, including prohibition of drug use *per se*, a ban on methadone and buprenorphine for treatment of opioid dependence, and a prohibition of "propaganda of narcotic drugs and psychotropic substances."

Children watch as riot police demonstrate an arrest using a dog during a youth antidrug event in Bangkok, Thailand. Pornchai Kittiwongsakul/AFP/Getty Images

Whatever the ideological differences between Russia and the United States may be, they seem to agree on a law enforcement-based approach to drug use. The second chapter of this section looks at the influence of the United States on the drug policies of its Latin American and Caribbean neighbors. Attempts by the United States to influence international drug policy are nothing new; indeed they date back to the Shanghai Opium Commission, convened by the United States a century ago in 1909.[8] More recent attempts by the United States to dictate the drug policies of other countries have focused extensively on Latin America, in fact, as the chapter notes, as much as 50 percent of U.S. foreign policy assistance in the hemisphere has been directed toward combating drug trafficking. These attempts include pressuring countries to eradicate their drug supply through drastic methods such as aerial spraying, as well as encouraging strict and punitive approaches to addressing supply of and demand for drugs. Plan Colombia, a predominantly military strategy shaped and supported by the United States, sought to tackle illicit drug production and trafficking, but may have resulted in the proliferation of the more dangerous cocaine-base paste, which can be produced in clandestine labs. In 2008, the United States supported Mexico to implement a similar plan to address drugs, called the Mérida Initiative, which also relies heavily on military and police forces, with few mechanisms for monitoring and oversight.

So far these tactics have proven unsuccessful in reducing supply as well as demand, but have led to overcrowded prisons ill equipped to provide appropriate disease prevention or treatment measures. Some countries in the region, however, are beginning to move away from the U.S. "War on Drugs" approach, and toward more humane policies, even though they face disapproval and sometimes repercussions from the United States for doing so.

Section III: Drug Control, Drug Use, and HIV: Reports from South and Southeast Asia

"Shadow reports" urge Pakistan, Burma, Thailand, and Vietnam to align policies on drug control and HIV.

The final section of this volume provides a survey of drug policies and their impacts on HIV and drug treatment services in three countries in Southeast Asia and in Pakistan. These chapters, which are intended as "shadow reports" to the official country progress reports, detail some notable findings. The Southeast Asian countries surveyed, Vietnam, Burma (Myanmar), and Thailand, are attempting to come to grips with growing populations of methamphetamine users. Approaches thus far have to a large extent centered on building an increasing number of drug treatment centers and "reeducation through labor" camps that have little evidence of effectively treating drug use, while often violating drug users' human rights and endangering their health in numerous ways. The Asian Harm Reduction Network, authors of the chapter on Southeast Asia, recommends reducing the number of drug users housed in custodial settings, including drug treatment programs, while instead instituting voluntary programs in the community.

In Thailand, known as a leader in the fight against AIDS for its "100 Percent Condom Campaign" to distribute condoms to sex workers, the approach to drug use has been markedly different—criminalizing people who use drugs rather than encouraging access to healthcare and disease prevention measures. Thailand's "War on Drugs" approach took an extreme form in 2003 when more than 70,000 people were detained without access to due process, and more than 2,000 were killed. Interestingly, while the policy was ostensibly enacted to address methamphetamine use, it may actually have had the unintended effect of prompting some drug users to switch from heroin to methamphetamine use when the drug war resulted in a spike in heroin prices.[9] While the country has since stepped back from such shocking practices, the government did declare a renewed drug war in 2008, though it has not, to date, taken the 2003 form of mass roundups and killings in the name of drug control. Still, drug users are interned in increasing numbers, without any means to prevent HIV transmission, which in a country where antiretroviral access is disproportionately unavailable to drug users, is in effect a death sentence.

Government policies have also had an unintended effect in Burma, where attempts to stem the tide of poppy cultivation have resulted in higher opium prices, and a concomitant switch from inhaling to injecting as a more efficient (and of course, also more dangerous) mode of administration.

The chapter on Pakistan describes similar unintended consequences of strict drug control policies. Following efforts to eliminate poppy cultivation in Pakistan and stop trafficking of poppy products from Afghanistan, opium and heroin, which were traditionally smoked in Pakistan, became increasingly scarce and prohibitively expensive for many. As Shamim details in her chapter, this has led to a shift to injecting cheap and readily available pharmaceuticals. With rates of HIV among drug users in Pakistan on the rise, existing services do not meet the needs for prevention and treatment, and at the same time, drug users face social stigma and police abuses. Shamim describes the impacts of these barriers in three case studies from drug users in Karachi.

Shaking the Foundations—Toward a New Approach to Drug Use

These pages represent only one of several efforts to raise civil society voices in the drug policy dialogue. In July of 2008, nongovernmental organizations from around the world gathered in Vienna to offer guidance to international drug control authorities about what was needed a decade after the Special Session. This gathering of more than 500 groups from 116 countries and 65 international organizations followed a series of earlier regional consultations where diverse groups, including those devoted to abstinence and zero-tolerance as well as those who believed that positive change could be achieved even without total prohibition on or cessation of drug use, considered the question of how far the world drug effort had come. Their consensus statement, included as an appendix to this volume, emerged through a consultative process similar to that engaged in by governments at the Commission on Narcotic Drugs. Strikingly, despite government proclamations of success in the drug arena, all those present made it clear that efforts to win the drug war had resulted in terrible collateral losses. Among the recommendations endorsed by all participants were calls to emphasize the need to adhere to human rights commitments, attend to the need for comprehensive health interventions in prisons and other closed settings, and ensure adequate supply of medications to treat drug dependence and relieve pain.[10]

These pages offer a less careful, more provocative call. It is unlikely that consensus declarations from Vienna will address the gross abuses of the kind that occur when Thai officials use blacklists and arrest quotas to round up, intern, interrogate, and sometimes kill those suspected of breaking drug laws. One cannot expect a system that requires agreement from all governments present to criticize a Member State by name, even when that State, like Russia, has a policy that denies essential medicines like methadone or

Indonesian drug users are chained at a "personal asylum for narcotics" in Jakarta. Such abusive conditions of detention often deter people from seeking treatment. Choo Youn-Kong/AFP/Getty Images

buprenorphine to millions at risk for HIV. This year, as the UN system assesses itself, we can safely assume that it will not find consensus on the proposition that its drug control efforts are fundamentally wanting. To quote the poet and activist Audre Lord, "the master's tools will never dismantle the master's house." We hope these pages will help to at least shake the foundations of the drug control system, and move those who have grown comfortable with its structures and assumptions to ask whether we are bringing more pain than progress through a drug control approach that fails to appreciate the value of health and human rights. In the words of one of the women interviewed about compulsory drug testing in China: "We are suffering, angry, screaming inside. Where is civility?! Where is human rights?! Where is justice?!"

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Notes

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Section I
A War on Drug Users: Police Abuse in the Name of Drug Control

Police Abuse of Injection Drug Users in Indonesia

Sara L.M. Davis, Asia Catalyst, and Agus Triwahyuono, Jangkar[11]

As the frequent target of anti-crime campaigns, injection drug users are highly vulnerable to abuse by the police. In Indonesia, an ongoing "war on drugs" has resulted in numerous arrests, and groups working with drug users have long heard anecdotal reports of torture and abuse in detention. Until recently, however, there was little effort to document or investigate the issue.

In late 2007 and early 2008, a coalition of grassroots groups in Indonesia set out to fill this gap. Jangkar, an association of nonprofit organizations working with injection drug users in Indonesia, conducted a survey of more than one thousand injection drug users about human rights conditions in police detention and at health care facilities.[12] More than 60 percent of the drug users interviewed said they had experienced some form of physical abuse by police.

The broader problem of police abuse in Indonesia has recently received quite a bit of attention. In November 2007, the UN Special Rapporteur on Torture conducted a mission to Indonesia, visiting police stations and prisons around the country and meeting with experts and nongovernmental organizations (NGOs). Torture is "routine practice" in Jakarta and other large cities in Java, he reported, and the conditions of detention in police stations amount to "degrading and inhuman treatment."[13] The absence of transparency and monitoring systems to hold police accountable for torture results, he said, "in a system of quasi-total impunity." Following the Special Rapporteur's mission, the Jakarta Legal Institute, a leading Indonesian civil rights NGO, published a survey in August 2008 finding that a majority of those in police detention were subjected to physical abuse.[14]

The Jangkar report gives a more detailed picture of how drug users experience abuse, and provides insight into the root causes of the abuse. It also raises concerns about Indonesia's approach to fighting the rapidly spreading HIV epidemic.

Until 1998, the Indonesian police were a part of the military force under the command of President Suharto, who used force to quell dissent.[15] Since that time, as part of broader efforts at security sector reform, Indonesia's police force has engaged in an extensive process of restructuring, separating from the military, and establishing itself as an independent public agency with new professional standards.[16] While this process has led to some notable achievements, many police officers themselves acknowledge that it is far from complete. The country's new police force faces an important challenge with rapidly

escalating drug dependence in Indonesia.[17] At the same time, injection drug use appears to be one of the key vectors of HIV transmission in the country, and prevalence among drug users is rising. Indonesia's public security forces and public health agencies urgently need effective and pragmatic responses to drug dependence and HIV.

Drug use in Indonesia

Drug use in Indonesia is, by all accounts, spreading rapidly. The number of drug users is debated: some health experts estimate between 200,000 and 500,000, while Indonesia's anti-narcotics chief estimated there were 3.2 million drug users in Indonesia.[18] Staff of Indonesian IDU NGOs estimate the number may be as many as 4 million today.[19]

Indonesia's response to drug use, like that of many other countries, has been punitive, with the launch of a national war on drugs and moral rhetoric condemning drug use. "Instead of making this country a heaven for drug traffickers, we will promise them hell," threatened the chairman of the National Narcotics Bureau (BNN), Inspector General I Made Mangku Pastika.[20] The drug war has included sweeping arrests and lengthy prison sentences for both traffickers and individuals found in possession of narcotics. Those found guilty of trafficking face more than nine years in prison or, in certain circumstances, the death sentence.[21] Those found in possession of even a small amount of narcotics may serve up to nine years in prison, including pretrial detention periods that can last months. Indonesian laws do not provide guidelines for sentencing based on the amount of narcotics in possession, so judges exercise wide discretion in drug cases, often issuing draconian sentences.

Lengthy and arbitrary sentencing results in overcrowding in Indonesia's prisons. Absolute numbers vary: According to the BNN, the number of drug-related cases increased from 17,355 in 2006 to 22,630 cases in 2008.[22] A UN statement in October 2008 estimated that 28,000 drug users were incarcerated at that time.[23] However, it appears that these numbers may underestimate the problem. The Ministry of Justice and Human Rights reported in April 2006 that of 89,000 prisoners housed in 396 prisons, most had been convicted of narcotics-related crimes.[24] Only one prison in Bali offers methadone on a pilot basis, which reached 33 prisoners as of June 2006, and no prison facilities offer needle exchange.[25]

HIV/AIDS among drug users

HIV prevalence is on the rise in Indonesia, and its rise directly parallels the increase in drug use.[26] Indonesia's "War on Drugs" approach has apparently been unsuccessful in curbing the spread of the disease. In late 1998, HIV prevalence was below 0.1 percent, but it began to increase rapidly in 1999-2000.[27] By 2006, the estimated prevalence was

0.2 percent, or about 193,000 people.[28] In 2008, the United Nations estimated 290,000 infections.[29] According to the World Health Organization (WHO) and the Indonesian Ministry of Health, roughly half of all drug users are HIV positive.[30] About 46 percent of people living with HIV/AIDS in Indonesia are injection drug users.[31]

Antiretroviral (ARV) treatment is available in Indonesia, though according to WHO and UNAIDS, ARV treatment was provided to only 6,600 people in 2005, constituting only 15 percent of the total number who need ARVs.[32]

Drug user NGOs report that drugs are widely available in Indonesian prisons,[33] while measures to prevent the spread of HIV are not. Many people who are HIV positive do not receive ARV treatment in prison; according to a media report, one prison is apparently distributing Chinese herbal medicines instead.[34] Outside of prison, national laws limit which agencies may distribute clean needles, and carrying a needle is illegal without a prescription. Under national regulations, police may not distribute clean needles even if they wish to do so.[35]

Drug user NGOs report that drugs are widely available in Indonesian prisons, while measures to prevent the spread of HIV are not.

Indonesia's punitive approach to drug use hampers government efforts to fight the AIDS epidemic. When drug users know they are at risk of arrest and may face torture, extortion, and long prison sentences, they are much less likely to come forward to participate in government and NGO-run HIV prevention programs. Instead, they are driven underground and are more likely to engage in unsafe practices such as needle-sharing and unsafe sex.

Over the past few years, drug users and former drug users around the country started mobilizing their communities at the grassroots level to fight AIDS. They established dozens of small NGOs to conduct outreach to drug users, established needle exchange programs, and began advocating locally and nationally for access to ARV treatment, harm reduction policies, and AIDS information. With limited resources, this growing network of small NGOs has achieved a great deal locally, persuading local hospitals to increase their stocks of ARV medicines, establishing kiosks with HIV/AIDS information, and placing dozens of peer educators on the streets for outreach to drug users around the country.

Methodology

Jaringan Aksi Nasional Penguran Dampak Buruk Narkoba Suntik, or Jangkar, is the largest of several national networks of drug user NGOs. Jangkar's network spans 75 organizations around the country, including groups of IDUs and migrant workers. Jangkar

A policeman in Jakarta walks past a campaign poster marking the United Nations international day against drugs, June 26. Ahmad Zamroni/AFP/Getty Images

defines itself as "the medium for communication among the institutions or individuals who have concerns about the prevention of HIV/AIDS transmission among drug users, especially those who intravenously inject drugs."[36] These groups rely on the efforts of an extensive network of field organizers, most of them former drug users themselves, who have strong contacts with current and former IDUs.

Beginning in 2007, Jangkar launched an extensive project to document rights abuses, including police abuse and discrimination against injection drug users in access to health services. Member groups in 13 cities participated in training workshops that introduced rights violation documentation standards.[37] The sampling relied on the existing networks of field organizers, who interviewed drug users on the street and in field offices. [See Table 1]

Jangkar used convenience sampling for this report, and asked those interviewed to refer others to participate. Interviewers, most of whom were field organizers, were instructed to interview any drug users with whom they had contact in local communities, but were also instructed to avoid weighting the sample toward those who had experienced abuse. In practice, it is likely that field organizers mostly interviewed those who already knew and trusted them, and to some degree, interview subjects may have self-selected for

Table 1. Number of drug users interviewed in 13 cities

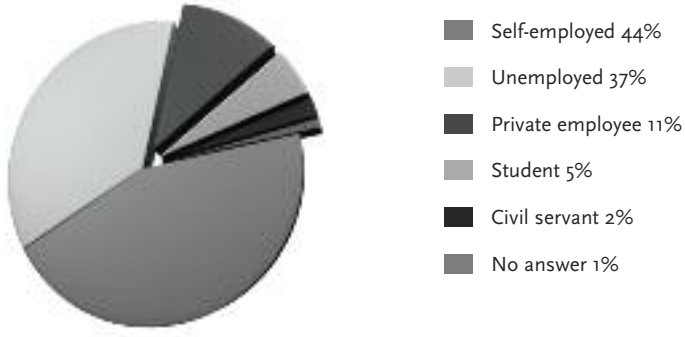
Citites	*Number of interviewees*
Palembang	97
Jakarta	117
Bandung	108
Semarang	83
Surabaya	61
Samarinda	61
Medan	68
Manado	100
Makasar	100
Denpasar	100
Ambon	56
Kupang	99
Jogjakarta	56
Total	**1106**

those who had some grievance. On the other hand, some drug users who did experience abuses were reluctant to participate in the interviews, saying that they believed the interviewer might be "a spy for the police."

To protect the anonymity of subjects, the interviewers used codes to identify them on all materials. Interview subjects were first interviewed using a simple questionnaire that asked only for biographical data (age, gender, occupation, educational level, and marital status). Interviewers also asked if subjects had experienced either police abuse or discrimination in access to health services. Those who said they had were then asked to share their experience in more detail, using a second interview form that asked for date, time, perpetrator, place of the abuse, details of the abuse, as well as physical, psychological, and social effects on the victim. Interviewers used audio recordings to back up their written interviews.

In addition, the first author spent about two weeks in Jakarta in October 2008, meeting with scholars, international donors, UN officials, and senior police officers. She also met with IDU NGOs from Jakarta, East Java, and Central Java, and held four consultations with a total of roughly 20 NGOs that work with IDU groups on the issue of police abuse against injection drug users. This article draws on those meetings as well as on the Jangkar report.[38]

Chart A. Occupation of Respondents



Research findings

The majority of the injection drug users Jangkar interviewed were educated and unmarried young men with some form of employment.

Of the 1,106 respondents, 985 (89 percent) were male. According to Jangkar, finding female interview subjects was challenging; this likely reflects the actual gender breakdown in the IDU population.[39]

Eighty-nine percent (987) of those interviewed had a senior high school-level education or above. Sixty percent (668) of the interviewees were single (never married). Slightly more than three-quarters, or 846, were between the ages of 25 and 34. Thirty-seven percent of those interviewed were unemployed, while 44 percent described themselves as "self-employed."[40] [See Chart A above]

While researchers did not attempt to confirm the details of individual accounts, commonalities in respondents' experiences indicate the widespread nature of police abuse.

Sixty-two percent of those interviewed reported experiencing physical abuse by the police. These incidents included beating of the feet, hands, chest, and head by officers using their hands, fists, and boots. In addition, several subjects said that police had beaten them with pistol butts, folded chairs, or blackjacks, and one reported being beaten with a wrench and the flat side of a metal saw.[41] Others reported being burned with cigarettes or given some form of electrical shock. One subject said that police stabbed him with a hypodermic needle that broke off in his skin.[42] Six percent of those interviewed reported sexual harassment or abuse, including inappropriate touching of women during street searches by male police officers.

According to the interview subjects, police abused IDUs for two reasons—to coerce a confession, or to extort bribes.

Coerced confessions

In many cases, subjects reported that police tortured them in an effort to obtain confessions. One young man, who said he was married and had a university-level education, described his arrest in Jakarta:

> Around 11 p.m. two policemen arrested me [at my friend's house]. They accused me of selling *putaw* [low-grade heroin]. They searched me and my friend. They found nothing. After 30 minutes, three more policemen came. One of them was the Unit Head. I was taken to a car. In the car I was beaten up and my toenails were pulled out so that I would admit that I sold *putaw*. It lasted four hours.[43]

In another case in Semarang, Central Java, a single man with a university education said he and his friends were beaten in an effort to compel them to sign a false confession:

> My eyes were covered with a bandage and I was taken to the police station. All of us were beaten up...We were also treated rudely when they were preparing the official report. They beat us up with a chair, rattan stick, and an iron ruler. The official report they made was not in line with the real events. We were not accompanied by any lawyer during the process.[44]

According to the interview subjects, police abused IDUs for two reasons—to coerce a confession, or to extort bribes.

Corruption

Police departments are under-funded, and despite ongoing efforts to fight corruption in the government, injection drug users report that they are often asked for bribes. In 2007, Transparency International surveyed roughly one thousand Indonesian citizens and found that a majority said the police were the government agency most likely to take bribes, an assertion the police rejected.[45]

Nonetheless, some of the Jangkar interviewees said that police beat them in order to extort "coordination fees," or bribes. In the words of a married man between the ages of 35 and 44 from Surabaya, who admitted that he sold drugs:

> I was often arrested previously, but since there was no evidence I was released. My family often gave ransom to the police to release me. Each time I was caught by the police, I was tortured.[46]

In Semarang, an injection drug user reported that he was beaten, threatened with a gun to his head, and released when he paid 20 million rupiah.[47] In a case from South Sumatra, police spotted a package of heroin sitting on the dashboard of a car and took the driver and his friend to the police station:

A drug user, his legs chained, sleeps on the floor of a Jakarta drug treatment center. The United Nations has yet to articulate guidelines for evidence-based drug treatment. Choo Youn-Kong/AFP/Getty Images

> He asked for "coordination money" from us. Because we said that we had no money, he took our wallets. As he only got a little money from our wallets, he asked for [my friend's] watch. I threatened the officer that I would report him to my uncle, who has a higher rank, but [the officer] only punched me. After he took the *putaw* and the watch we were finally released.[48]

NGOs working with drug users and organizations providing legal services to them report that corruption is widespread throughout the criminal justice system. Lawyers say that drug users may be asked for bribes by prosecutors in exchange for lighter charges, and from judges in exchange for lighter sentences.[49]

Drug users who requested medical treatment for injuries sustained during interrogation said they were sometimes refused, as in the case of this man from Surabaya:

> They tried to make me tell them where I bought the *putaw*. I refused to give any information. The police got impatient and hit me. One of the policemen folded a chair and used it to beat me all over my body. I broke my left hand. I gave the information eventually, because I could not stand it anymore.
>
> I begged them to take me to a hospital, but they laughed at me and said that I was fortunate that they had only broken my hand and did not shoot me in the kneecap.[50]

Two drug users interviewed for the Jangkar report said that they were refused access to ARV treatment while in detention in the police station; they also said that police disclosed their HIV status to others.[51]

In addition to physical abuse, respondents said that some police used threats to both drug users and their families, as well as public humiliation, to coerce confessions or extort bribes. Half of those interviewed reported some form of psychological abuse, including verbal abuse, being threatened with a gun, and other threats. In one case, an interviewee was forced to strip and submit to a search while standing on a public street.[52]

Two drug users said that they were refused access to ARV treatment while in detention in the police station; they also said that police disclosed their HIV status to others.

When incidents of the kind described by the Jangkar report happen occasionally, they may be the fault of rogue officers. When they happen repeatedly, and take similar forms in a variety of locations and times, they point to a pattern that is broader than the problems of any single police station, officer, or province. Solutions that have worked in other countries include system-strengthening within the police force, and legal reforms to protect the rights of people in custody.

Addressing systemic problems

Police forces that transition from military to civilian control are often plagued by reports of police abuse.[53] While Indonesia's police have made strides in establishing themselves as an independent civilian force in the past ten years, international experts who have studied ways that other countries have effectively addressed police abuse recommend that the government also establish clearer systems for evaluation and promotion, systems for police accountability, an independent and transparent civilian complaint mechanism, and adequate staff compensation to remove financial incentives for corruption.[54] The government should take steps to enforce the UN Convention Against Torture, which mandates several of these measures, and to ratify and implement the Optional Protocol of the Convention Against Torture.[55]

Since 1998, Indonesian police have participated in an extensive process of security sector reform. The military has gradually removed itself from governance, and the police, in turn, have separated from the military. The new systems they have established include: clarifying the respective functions of the military and the police, creating a national Police Law, creating new codes of conduct, uniforms and ranks, and undergoing extensive training—overall an ambitious project, made even more challenging in the context of the 2002

bombing of a Bali nightclub frequented by tourists and the concomitant concerns about terrorism.[56] Yet senior Indonesian police experts such as Adrianus Meliala note that progress has not included adequate steps to ensure accountability.[57]

An independent mechanism within the police department to accept, investigate, and handle complaints from the public is a measure that has proven, in other countries, to reduce the number of abuse incidents.[58] Currently, there are two such mechanisms in Indonesia, but by most accounts, neither functions effectively.

The National Police Commission (Kompolnas), which functions at the national headquarters level, is charged by law with advising the president on the budget and personnel of the police, and also accepts complaints from the public about the performance of the police.[59] Profesi dan Pengamanan, (Probam), the ethics and discipline division of the police, also accepts complaints orally or by letter. In addition, some chiefs have reportedly gone so far as distributing their own cell phone numbers to members of the community in order to collect reports of abuses.[60]

In Surabaya, lawyers report that police are using methods such as waterboarding and suffocation with plastic bags in order to avoid leaving marks.

Yet according to experts in the field and community lawyers, neither of these agencies has had the clout to hold police accountable. Currently, according to one lawyer who provides legal aid to those accused of crimes, "torture is considered as a mere disciplinary breach; thus, the perpetrator gets lenient punishment, and indeed only administrative penalties."[61] Moreover, neither Kompolnas nor Probam issues reports to the public on the number or outcome of these cases.[62]

In addition, according to lawyers working with police abuse victims, Probam may require a higher standard of evidence to support complaints than is feasible in cases of torture by police officers. For instance, lawyers may be asked to produce witnesses or photographs to prove that torture actually happened. In Surabaya, lawyers report that police are using methods such as waterboarding and suffocation with plastic bags in order to avoid leaving marks.[63] The UN Special Rapporteur on Torture, Manfred Nowak, recommended in his report on Indonesia that the burden of proof in such cases should lie with the prosecution rather than the defense. He suggested that the law should require prosecutors to prove that abuse did not occur during interrogation, and recommended that police record or videotape confessions as evidence that they were obtained without force.[64] Custody registers are also rarely used in Indonesian police stations, but they could help to guard against the problem some drug users report of friends "disappearing" into detention.[65]

A second critical step in any program to deter abuse is the establishment of a clear system for evaluation and promotion of officers. Promotions should take into account a variety of factors, including the numbers of complaints against an officer. In Indonesia's "War on Drugs" environment, where there is intense pressure to increase the number of arrests and no other clear system for evaluation and promotion, officers may use violence in an effort to coerce confessions and raise the number of convictions.

A chronic lack of funding for the police force could be another cause of the extortion of bribes, though as one police officer asked rhetorically, "How much money will be enough?"[66]

Where there is intense pressure to increase the number of arrests and no other clear system for evaluation and promotion, officers may use violence in an effort to coerce confessions and raise the number of convictions.

International support to date has largely focused on providing training to officers at every level of the system. Training will be important as the police work to develop an understanding of and respect for human rights, but without mechanisms in place—and proper funding—to create a framework that supports human rights in practice, training alone will not stop police abuse. Indonesia could draw on the experience of police forces in other countries to learn how they have established mechanisms within the police to prevent abuses of the kind detailed here.

Legal reform

While structural weaknesses within the police system are important to address, reforming the legal framework is in many ways even more critical. According to Indonesian legal experts and drug user advocates, priority areas for legal reform include: extremely long pretrial detention periods, heavy reliance on confessions for evidence in court, barriers to access to legal counsel, and the difficulty of challenging illegal searches and detentions in court.

One of the key factors often leading to abuse in detention is the length of the detention period for drug users. The UN Special Rapporteur on Torture, Manfred Nowak, recommends:

> As a matter of urgent priority, the period of police custody should be reduced to a time limit in line with international standards (maximum of 48 hours); after this period the detainees should be transferred to a pretrial facility under a different authority, where no further unsupervised contact with the interrogators or investigators should be permitted.[67]

Demonstrators in Bandung, West Java call for an end stigma and criminalization of drug users and those living with HIV. Courtesy of Rumah Cemara

However, injection drug users in Indonesia can be legally detained for periods of up to eight or nine months before sentencing. If a suspect is facing a prison sentence of longer than nine years (i.e., for trafficking), she or he may be detained for up to 120 days, through a series of renewable detention periods. The prosecutor can then detain the suspect for up to an additional 110 days pending trial, and during the trial, the judge can detain the person for 150 days more. In a worst-case scenario, therefore, a suspect faces a potential detention period of eight to nine months before sentencing. In practice, lawyers say, most are detained for between two and four months.[68]

A draft narcotics bill (Rancangan Undang-Undang Tentang Narkotika) currently under discussion provides an opportunity to bring detention periods into line with international standards; however, drug user advocates who have seen the bill say the current draft does not include the recommended reform.

A second important issue is the Indonesian courts' reliance on confessions as sole or primary evidence, without placing the burden of proof on police and the prosecutor to show that these were obtained without coercion. Indonesia's Criminal Procedure Law (KUHAP) does give individuals the right to remain silent and the right to be free from duress during interrogation.[69] Furthermore, if a suspect or her lawyer alleges that torture

was used, they should be able to obtain an independent medical evaluation; but in practice, according to drug user NGOs, only doctors working for the police do these evaluations.[70]

Those charged with a crime should have the ability to challenge the legality of their detention in court. While this right currently exists, according to Nowak, it is rarely exercised in practice.[71] In addition, a number of those interviewed for the Jangkar report said that their persons, homes, or cars had been searched without a legal warrant. Under Indonesia's criminal law, victims do have the right to compensation for illegal arrest, detention, or asset seizure, but in practice, this right is rarely exercised.[72]

Finally, exercising all these rights is challenging without access to legal counsel. Under the criminal law, law enforcement agencies are obliged to appoint legal counsel for a defendant facing 15 years' or more imprisonment or the death penalty; for those who are impoverished and facing a sentence of five or more years, law enforcement agencies must also appoint legal counsel.

Many drug users are reluctant to accept the services of a lawyer for two reasons: because the involvement of a lawyer may suggest to police and the prosecutor that the crime is more serious, and because it may signal to corrupt police that the detainee has financial resources.

However, lawyers and IDU activists all reported that many drug users are reluctant to accept the services of a lawyer for two reasons: because the involvement of a lawyer may suggest to police and the prosecutor that the crime is more serious, and because it may signal to corrupt police that the detainee has financial resources.[73] A staff person at Stigma, an NGO working with drug users, said that in five recent cases where Stigma offered to provide a lawyer free of charge, clients all refused the services.[74] It may take some time to strengthen the legal system, and to educate the public, in order to reach the point where drug users feel able to exercise their rights under existing law.

Rehabilitation vs. prison

A beam of light in this otherwise bleak picture is that national policy provides judges with the option to sentence drug users to rehabilitation instead of prison. However, this is an option judges rarely exercise, and there are only 45 drug rehabilitation facilities in the country, which is not enough to meet the demand.[75] International donors and Indonesian NGOs might consider partnering with the judiciary to hold workshops and provide educational materials on drug addiction, in order to make judges aware of the benefits of sentencing drug users to rehabilitation facilities.[76]

Looking forward

There is no country in the world that has not been plagued by police abuse. As a marginalized group, drug users everywhere are vulnerable to these kinds of abuses; they may "disappear" into the prison system without causing a ripple in the social fabric. In the current political climate, in which the international war on terror and the war on drugs have degraded global rights standards, it is increasingly challenging to advocate for detainee rights or to combat torture.

Current efforts to draft a new Indonesian narcotics bill provide one opportunity for reform. At the same time though, social pressures, including the rise of conservative religious constituencies who view a punitive approach to drug use as a moral imperative, may create challenges for those advocating that drug dependence be treated as a medical condition rather than a moral failing. Finally, a widespread cultural acceptance of beating by police poses another obstacle to advocates fighting abuse.

Even in the best of circumstances, it is impossible to eradicate police abuse altogether. But the problem can be reduced, and police can create mechanisms to improve their own professionalism, protect human rights, and allow effective redress to victims. The stated commitment of Indonesia's police to ongoing system reform and improvement of their professionalism creates openings to propose changes that could significantly reduce police abuse against drug users. At the same time, the accession of Indonesia to the Optional Protocol to the Convention Against Torture and its review in 2009 by the UN Committee for Civil and Political Rights will provide Indonesia with opportunities to reform the Criminal Procedure Law and bring laws and practices into compliance with international human rights standards. These steps are not only critical to combating police abuse and to the continuing evolution of Indonesia's new police force; they are also necessary steps in the fight against the twin epidemics of drug dependence and AIDS.

Notes

11 The authors are grateful to all those who assisted with this article, including Nick Bartlett and staff of IHRD at OSI; staff of Jangkar, Stigma/Forkon, LBH, Kontras, and other IDU NGOs in Jakarta and Surabaya; as well as to Prof. Andreas Meliala, Monica Tanuhandaru, Ricky Gunawan, Sidney Jones, Joe Saunders, Gabor Somogyi, Fabio Mesquita, and Lisa Misol for their guidance. Any remaining errors are the authors' fault alone.

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48 Jangkar interview with ANDA78-PLG, Palembang, November 29, 2007.

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76 Some international experts on drug dependence in Indonesia raise concerns that these rehabilitation centers are weak, as they may be developed by NGOs and former drug users without reference to international scientific expertise. Indonesian drug user advocates spoken to for this article asserted that they believed these facilities could be effective. International assistance in strengthening rehabilitation options to include methadone treatment and community-based care could be a helpful area of cooperation in the future.

Arbitrary Detention and Abuse of Drug Users in Cambodia

In February 2008, Cambodia passed an anti-trafficking law sponsored by the United States that labels drug users as a "high risk population for being trafficked," thus giving authorities the freedom to send drug users to "reeducation camps," ostensibly for their own safety. Since this law was passed, more than 300 drugs users in Phnom Penh have been detained in such centers; upon release they are reporting a plethora of human rights violations.

Background and goals

This study includes interviews conducted from January through April 2008 in collaboration with a local harm reduction nongovernmental organization in Phnom Penh, the Cambodian capital. Through street outreach and a drop-in center, the NGO provides needle exchange, overdose prevention training, case management, peer education, and medical treatment. Since gaining access to these services, injection drug users have become more involved in the process of advocating for additional services. They have done this in part by making their needs known to service providers. These interviews contributed to that process of empowerment that enables them to express themselves freely and articulately.

Methodology

Researchers conducted short interviews with drug users to identify participants who had experienced police abuse and who were willing to share their stories. The large number of drug users who have had their human rights violated in Cambodia made eligible participants easy to find. This also made it possible to screen participants as to include an array of demographic characteristics, from nationality to HIV status to age. Though four out of five case study participants are female, this is not representative of the overall population, as the majority of IDUs in Cambodia are male; however, the number of female IDUs is steadily increasing.

Interviews with the participants were conducted over a period of three months. Interview questions were developed based on the interviewer's previous knowledge of the difficulties facing Cambodian IDUs. Each participant was informed that they were welcome to refuse to answer any questions. In general, once participants understood that the study would be used to advocate for the human rights of people who use drugs, they were

very willing to provide any information they thought could help. Participants were given $75 USD as remuneration.

Srey Mao

Srey Mao has been living in Phnom Penh since the age of 19 when she came from her mother's house in the Cambodian Province of Svay Reang. Her father left the family when she was just four years old, forcing her mother to support them by herself.

One year after coming to Phnom Penh, Srey Mao got married. Two years later she gave birth to a baby girl. Two years after that she began using heroin.

Srey Mao reports that arrests are common if the police feel they can get a large sum ($25USD) of money in exchange for release. The police also frequently extort money from Boeung Tra Bek's residents, generally asking for 5,000 riel ($1.25USD) or demanding liters of gas to be bought for them, which are approximately the same price.

Srey Mao was introduced to heroin by a group of friends in Phnom Penh. Srey Mao says she uses heroin to forget her pain about her family. At around the same time, she also began using yama, a form of methamphetamine diluted or "cut" with a variety of other chemicals, which is very common in Southeast Asia. Soon after Srey Mao started using drugs, she sent her daughter to live with her mother in Svay Reang. That same year Srey Mao gave birth to her second child, a son.

Srey Mao became homeless as a result of forced eviction when the government decided to claim the land she was living on. This happened shortly after the birth of her son, but she was determined to keep him with her despite the circumstances. They began living in a temple, Wat Koh, where many of Phnom Penh's drug users lived at the time. Her husband was absent most of the time, showing up only sporadically. Srey Mao realized that was not the life she wanted for her son. She felt she was unable to give him the care he required and decided to give temporary custody of him to the orphanage Mith Samlanh. She felt that with her son entrusted to the care of Mith Samlanh, she would be able to stop using drugs and transform her chaotic lifestyle into one that would better suit her children.

Subsequent to this decision, Srey Mao remained homeless. She relocated to Boeung Tra Bek. Boeung Tra Bek is a district of Phnom Penh now known for its widely available heroin, and the open-air injection of drugs that takes place there.

Boeung Tra Bek also has a strong police presence. Srey Mao reports that arrests are common if the police feel they can get a large sum ($25USD) of money in exchange for release. The police also frequently extort money from Boeung Tra Bek's residents, generally asking for 5,000 riel ($1.25USD) or demanding liters of gas to be bought for them, which are approximately the same price.

Srey Mao has been arrested by both the police and the Department of Social Affairs in the past. In four out of five arrests she was released to the care of an NGO. Her fifth arrest took place during a holiday and she did not have the option to call an NGO, as they were all closed. Srey Mao was brought to Oksas Knyom ("My Chance"), a drug treatment center operated by the military police. En route to Oksas Knyom, Srey Mao asked the reason for her arrest. She was told it was for "sleeping on the streets before a holiday."

Upon her arrival to Oksas Knyom, Srey Mao looked in terror at the 18-room compound. She was brought inside and locked in a room with 29 other people, no beds, no mosquito nets, and no toilet.

While there she received food twice daily, once at 10 a.m. and once at 4 p.m. These were also the times she was released from the locked room to bathe, use the bathroom, and get water.

Srey Mao did not receive any medication to lessen the physical discomfort of her heroin withdrawal. She also did not ask for medication, for fear of being beaten by the guards. Srey Mao reports being beaten with sticks regularly during her time at Oksas Knyom. She states that the guards told her that their reason for beating inmates was so that they "learn not to use drugs and that being an injection drug user is disgusting and bad."

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Srey Mao said that an inmate was attacked by four or five guards and beaten for requesting medication. He was beaten to the point of unconsciousness and then dragged from the room and placed in a solitary confinement cell. Srey Mao explains that if the beating is severe enough to be fatal, the guards often remove the victim's nearly lifeless body and dump it on the side of the road. This is done in an attempt to disconnect the guards from the murder.

A woman, nine months pregnant, and her four-year-old son peer out of Koh Kor detention center after being caught up in a police raid and detained with other "undesirables." Those rounded up were held without charges in the former Khmer Rouge execution camp. Courtesy of LICADHO

On Srey Mao's third day at Oksas Knyom she decided she had seen enough. Srey Mao escaped during the earlier of the twice-daily releases. She returned to Boeung Tra Bek a few hours later. Srey Mao says she would never consider returning to Oksas Knyom because she is terrified of being beaten, and the living conditions were horrendous. She feels Oksas Knyom is beyond the point of redemption, even with international assistance, and that it should be shut down for good.

Srey Mao expresses a strong desire to maintain abstinence from heroin, but feels without help she will be unable to stop. She has recently reduced her injection use by half, citing as reasons the latest increase in the price of drugs and her hopes for her children's return to her care.

Srey Mao missed her son and decided to go to Mith Samlanh orphanage for a visit. Her agreement with Mith Samlanh had been that her son would remain at their Phnom Penh center and she would have the option to visit or regain custody of him at any time. She arrived at Mith Samlanh and was unable to find her son. When she asked the center's staff about his whereabouts they did not provide her with an answer. Staff told her they would send someone to Boeung Tra Bek the following day to speak with her. Two weeks passed with no word about her son.

Srey Mao returned to Mith Samlanh demanding answers. Staff told her that her son had been given to her mother-in-law in Battambang, a city four hours north of Phnom Penh. Srey Mao did not authorize this decision; in fact she was unaware of it until that moment. Srey Mao told the staff she wanted her child immediately returned to her so she could take him to live with her mother and daughter in Svay Reang. They refused. It has now been eight months since that conversation and all that Mith Samlanh has been able to show Srey Mao are three very out-of-date photographs of her son. She continues to actively pursue the issue and now has free legal representation provided by a local NGO.

Srey Mao still lives on the streets of Boeung Tra Bek and plans to discontinue her drug use, find employment and housing, and have her children returned to her care. Until then Srey Mao proves her determination and will in the case of her son, and continues to be an influential voice for drug users. Srey Mao is recognized among her peers as a natural leader who is able to maintain her pride and dignity, even in the most difficult times.

May

May was born in Vinh Ko Province in Vietnam. She left home at the age of 14 to find work and help her parents support their family. Two years later she came to Phnom Penh with a group of her friends in hopes of starting a new life.

When May was 23 she got married. Shortly after her wedding her mother passed away. Soon thereafter she began using heroin. May says she first used heroin to suppress

the feelings of grief she had surrounding her mother's death. She says she continues using heroin because it eliminates her worries about her home and family in Vietnam. When it was brought to the attention of May's family that she was using heroin, they disowned her. May's husband also divorced her, citing family pressure to "find a better wife who was not a drug user" as a reason.

Three years after she began using heroin, May remarried and gave birth to a baby girl. At the time she was living in an apartment in Phnom Penh; one year later she became homeless when she was evicted for nonpayment of rent. May, along with her husband and daughter, relocated to the streets of Boeung Tra Bek.

In addition to May's daughter, there were two other children in the cell. One was a six-month-old baby boy and the other, a 10-year-old boy. All the children had been incarcerated along with their parents. May reports that the guards at Galop 4 treated the children as if they were inmates; the children were denied use of the toilet unless it was during a release time.

May decided to stop using drugs. She maintained abstinence for two months, but felt pressured by her friends to use. She says she began using again because she felt like she had no family.

Soon after she returned to using heroin, May was arrested for injecting drugs. She was taken into custody along with her two-year-old daughter, and they were brought to a detox center called "Galop 4." They were placed in a locked room with 29 other people and no water, no toilet, and no beds. They were let out of the cell twice daily to shower, use the bathroom, get water, and eat. The food, she explains, was less-than-adequate portions of rice and small amounts of vegetables.

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May explains that the 10-year-old boy had been brought in with his father. The boy had been crying for six days, complaining of a stomach ache, and was completely ignored and denied medical care. On the night of the sixth day the guards took pity on the child and allowed him to go outside to play. The boy ran away from Galop 4 following the advice of his father. May explains that he was a street kid and was probably accustomed to taking care of himself.

May received no education about drug use or anything else while in Galop 4. When asked whether there were any support groups in the center, May laughs and says "No. Nothing like that." She reports she was not offered any medication to lessen the physical effects of her heroin withdrawal, and when she asked for aspirin she was yelled at and denied.

A few days after the little boy escaped, a man attempted to escape during the afternoon release. Three guards caught him and dragged him across the yard beating him with batons in plain view of everyone, including the children, until he was unconscious. The guards then tied the man's unconscious body to a tree and left him there for the night. When May woke up in the morning the man was gone; the guards claimed he had escaped.

May feared for the life of herself and her daughter. She escaped with her daughter during morning release that day. She returned to Boueng Tra Bek. Her daughter was then taken into the custody of her husband's family and now lives in Vietnam.

She reports she was not offered any medication to lessen the physical effects of her heroin withdrawal, and when she asked for aspirin she was yelled at and denied.

May feels that, as a drug user, people automatically assume she is HIV-positive and look at her as inferior. Most Cambodians lack education about HIV, and therefore tend to make their own assumptions about the virus. May has never been tested for HIV because she assumes that her daughter and husband are negative, and that she is as well.

May expresses her desire to stop using drugs and has reduced her heroin use by half. She and her husband currently work as "recyclers," collecting cans and bottles to sell to local recycling centers. They earn a combined $5USD per day doing this, half of which they spend on heroin. May says that heroin prices have recently doubled and this has made it more difficult to obtain. She often has to split the cost of heroin with others in order to be able to afford it.

May hopes to find steady employment, though she is not actively looking right now, and then to find affordable housing. She feels that she will be a good citizen, something very important to her, if she stops using drugs.

May remains strong through her daily struggles with homelessness and drug use. She hopes that police will stop doing roundups in her neighborhood and bringing those detained to detox centers like Galop 4. She states that no one actually gets help at detox centers and that, by bringing people there, police are just leaving them for dead. May also

hopes that police will become better educated about, and therefore more understanding of, people who use drugs.

Pean

Pean spent her childhood in the midst of Vietnam's war, and her adolescence as a witness to its aftermath. She came to Phnom Penh, Cambodia from Vietnam at the age of 18. She and her mother were in search of work and a better life. Pean was married that same year. Two years later she gave birth to a baby girl. Two years after that she became pregnant again right before her husband left for a business trip to Thailand. Her husband was murdered by his business partner in a dispute over money on the trip. The partner told Pean that Thai locals had murdered her husband. She never saw the partner or her husband again.

Shortly after, Pean delivered their second daughter. Pean spent the next 11 years raising her girls in Kandal, a province near Phnom Penh. She remarried in 2004 to her current husband, a heroin user.

The beginning of their marriage was stressful for Pean. They were constantly short on rent, or going without food so her husband could maintain his drug use. After two years of marriage, the couple found themselves expecting a baby. Pean hoped that with a baby coming, her husband would change his ways.

Eight months into the pregnancy nothing had changed. Pean caught her husband stealing from her stash of money more than once and was extremely angry. Her husband had a plan of his own to make her understand. Pean says her husband forcibly injected her with heroin several times a day. By the time she delivered their son she was hooked.

When asked how she feels about her husband, Pean tells me "I hate him more everyday. What he did is unforgivable, and now our relationship is totally based on drugs. As soon as I quit I am leaving him."

Pean tells me that there is nothing she likes about heroin. She feels her lifestyle and addiction forced her into the decision to give up her son for adoption. Her eyes fill with tears as she says, "I had a lot of friends before I started using, but they don't want anything to do with me now. They judge me based on my lifestyle, they won't even look me in the eye."

Pean and her family were evicted from her apartment shortly after the birth of her son. She was unable to pay rent since now all of her money was going to buy drugs. She and her family began living on the street in Boueng Tra Bek.

Soon after this move, Pean was arrested while talking to a fellow drug user on the side of the road. They gave her no reason for her arrest. They took her to Toul Supee, also known as Prey Speu. Pean describes it as "the jail for beggars;" the Cambodian government describes the three-month program as a reeducation camp for the homeless. She says she did not receive any education while she was there.

A mentally ill man lies covered in his own excrement at Koh Kor detention center. Detainees were not screened for physical or mental health issues and had no access to medication or health workers. Courtesy of LICADHO

Pean began experiencing withdrawal symptoms on her first day at Toul Supee. When asked if she got any medication to lessen it, she says "I would have asked, but there was no one there to ask." No guards? "There were no guards. Only the cow people." Cow people? "Yes, the people who made sure no one stole the cows they had on the property."

Further questioning revealed that Toul Supee is a military camp from the Khmer Rouge era that the Cambodian government turned into a reeducation camp for the homeless. Ten people were kept in each room and made to sleep on the floor. "There were a few orphans, about five or six years old, and the oldest person was probably about 70," said Pean.

Inmates were made to bathe in and drink from the same troughs as the cows. They were let out of their rooms once per day to bathe, drink, and eat. Pean reports that their only daily meal consisted of a tiny portion of uncooked rice and a small serving of rotten vegetables, sometimes containing worms.

On Pean's second day there she was bathing and took longer than the cow guards felt she needed. Two female and two male cow guards beat her with 2x4 boards and dragged her back inside and locked her in a room. Medical tests conducted when she returned to Phnom Penh revealed her hand was broken and she had a severe lower back injury that still causes her to limp; both results of the beating.

Pean was in her room when she witnessed an inmate in her 40s hitting the walls, screaming and yelling, and demanding food and water. Three of the cow guards burst into the room and began beating the woman with sticks; they continued beating her until she was unconscious. After she was unconscious for a few minutes the guards poured water over her to wake her up; when she came to, they began beating her into unconsciousness again, then dragged her from the room, telling the other inmates they were taking her to the hospital.

Pean was terrified after witnessing this; she knew she could easily be killed in Toul Supee. She made the decision to escape. The following morning she climbed out the window, across the roof and jumped from the roof of the two-story building to the other side of the fence surrounding the property. She made her way toward town where she caught a motorcycle taxi. It was the moto taxi driver who told her about the woman's body that was found that morning, beaten beyond recognition and dumped on the side of the road near Toul Supee.

She wants to go to detox, but is too traumatized from her experience at Toul Supee to trust any government-run programs to help her.

Pean reflected on this information during her two-and-a-half hour ride back to Phnom Penh. Then she went to find some heroin. That was one month prior to this interview.

Pean used her participant stipend to secure an apartment. She is not sure how she will pay the $40USD monthly rent beyond this month. She currently works as a recycler, collecting cans and bottles from the street and selling them for three cents each to the local recycling center. She also plans to purchase an abjie cart, a large wheelbarrow-like cart made from wood and chicken wire, with which she will be able to collect more cans at one time.

Pean is trying to quit using heroin and has cut back from injecting four times per day, to injecting twice a day. She says she would quit completely, but she can't sleep unless she is high and she always gives in to the effects of withdrawal. She says she plans to quit completely in one month. She wants to go to detox, but is too traumatized from her experience at Toul Supee to trust any government-run programs to help her.

Pean feels that once she quits using drugs, her self-confidence will increase, and she will be able to start a career and maintain her housing. Until then, she says she wants people to accept her for who she is and not look down on her because of her lifestyle or her past.

Chamda

Chamda comes in for her interview and excitedly sits down, eager to share her experiences. She is wearing a bold red "protection" bracelet,[77] which brightly stands out against her muted, dusty ensemble. The front of her hair has been completely scorched off.

Chamda's life began 32 years ago in Kratie Province in northeastern Cambodia. She lived with her family until she married at the age of 18. After one year of marriage, her husband disappeared to Phnom Penh, leaving Chamda alone and pregnant.

Following the birth of her child, she took her infant son and went to Phnom Penh to find her husband. She discovered him married and living with another woman. The woman decided to leave him after learning that he had fathered Chamda's child.

Three years later, Chamda and her husband had a second son. One year after the birth of their second child Chamda became pregnant again. She felt her relationship with her husband was not stable, and feared he would again leave her for another woman.

Chamda decided to terminate the pregnancy, something she now says she regrets deeply. Cambodia is a Buddhist country and abortion is illegal and considered exceedingly immoral according to tradition, no matter the circumstances. Women who choose to have an abortion often do so in secret, for fear of being shamed or disowned by their families. Abortions regularly take place under very unsanitary conditions and are performed by unqualified individuals looking to make extra money.

One year after her abortion, Chamda became ill with a stomach virus. A friend of hers gave her heroin to smoke, claiming it would lessen her stomach pains. Chamda smoked every day for a week. She stopped when she began feeling better.

Several hours after stopping, she began vomiting and having diarrhea. She had remembered seeing an educational show on "HIV and its symptoms" on Cambodian television that said that vomiting and diarrhea were the most common symptoms of HIV. Remembering her husband's affair, Chamda made her way directly to the local clinic for an HIV test, cursing her husband the whole way. She told the doctor everything, from the affair to the heroin smoking.

Chamda's HIV test proved negative and the doctor explained heroin addiction and withdrawal symptoms to her. As Chamda understood it, the only way to feel better was to smoke more heroin.

The more she smoked, the better she felt. Chamda says heroin helps her forget about the tragedy in her life. She also began smoking yama, a form of methamphetamine which, with prolonged use, frequently causes psychosis. She tells me "When I smoke yama I feel motivated and energized for work."

Chamda's life became completely focused around drugs and she began injecting heroin. For the next several years she managed to keep her home life separate from drugs, staying in an apartment with her husband and three sons.

Four years passed, and Chamda began stealing laundry to sell at the markets to pay for drugs. She was caught and arrested. She was brought to the police station and put in an interrogation room where two male officers hit her repeatedly with the butt of a gun, kicked and punched her. Chamda recalls that they demanded she tell them who her accomplices were; as she had none, she had no one to implicate. They beat her until she was coughing up blood, then continued beating her until she was unconscious.

When Chamda woke up she was alone on the floor of a prison cell of a local police station. Looking around, she saw two metal bed frames with no mattresses and a small locked window. She still remembers the stench from the urine and feces on the floor.

Shortly after regaining consciousness a male officer came into her cell. He closed and locked the door behind him. He told her that for $100 USD she could walk out of the station a free woman.

Shortly after regaining consciousness a male officer came into her cell. He closed and locked the door behind him. He told her that for $100 USD she could walk out of the station a free woman. She told him she didn't have any money. He began forcefully trying to remove her clothes, but she pushed him away. He continued aggressively and savagely, punching her and trying to rape her; she fought him off and screamed for help. After several minutes, another guard came to see what was going on, at which point the man left the cell laughing and saying how much he hated thieves.

Chamda was kept in the cell for four days, receiving unprovoked kicks, slaps and punches at least twice a day. She was let out once a day to use the bathroom. She explains that if someone defecated on themselves and did not clean it immediately, the guards, who had just refused them the use of a toilet, saw this as an invitation for a beating.

When Chamda began having withdrawal symptoms in addition to coughing up blood from the brutality of the beatings she had been receiving, she asked to see a doctor or to be given medication. She was fiercely denied and told there was no money for medical supplies.

Chamda says, had she had money, she could have easily taken her mind off of her withdrawal by purchasing some of the readily available yama and ice (a purer form of yama) from the guards for twice the going street rate. She says that upon special request, heroin was also made available.

In the four days Chamda was held she received only one meal, bought for her by a guard, and one bottle of drinking water. She was released when her abuse-induced condition of coughing up blood worsened, and a senior officer "took pity on her." When I asked if there were any rules in the prison, she said she was only told one, "If you run, we shoot."

When Chamda returned home, she also returned to using drugs. She was hired by a local NGO as a cleaner. She worked there almost a year and was then let go after 30 days of consecutive absence. She is currently trying to get re-hired.

Chamda is now self-employed as a "recycler." She collects bottles and cans and sells them to the recycling center for 100 riel each (approximately 3 cents USD). She makes about $2.75USD a day.

Chamda says she is stressed about being able to afford rent. Her husband died 15 days earlier ago of liver failure. "That's what happened to my hair," she says. "The loss was too much for me to take. I don't know how I will support my family. We are going to end up on the streets. I didn't think I could handle it, so when they put his body in the cremation oven I jumped on top of it. I was pulled out by the monks, but all my hair got burnt off."

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She said she no longer feels this way, and plans to use the money from her participant stipend to pay her rent. Chamda is still unsure of what she will do beyond that. She says that drug prices have recently doubled to $2.50USD for a bag of heroin, and that has put extra financial pressure on her. She frequently has to beg drug dealers, or share the cost with other heroin users to maintain her habit.

She mentions her desire to stop using drugs but admits she is not actively trying, though she wants to so she can see her sons grow up. She also hates the way society looks down on drug users, saying that 90 percent of the people are uneducated therefore they treat drug users without dignity. The other 10 percent, who have received proper education, are compassionate and nonjudgmental, she says.

If Chamda stops using drugs, she plans to save up money to start her own business. She is optimistic about being a good citizen and aspires to someday help educate Cambodian people about HIV. She feels that if she can do this she will be able to maintain abstinence from drugs and provide a good life for herself and her three sons.

Drug users sleep on the floor of a drop-in center in Phnom Penh to avoid police raids on the streets. Courtesy of Long

Young Kor

Young Kor was born in the Cambodian province of Tah Kamao in 1985, just six years into Cambodia's process of rebuilding itself after the Khmer Rouge regime had fallen.

Young Kor was born to a single mother who put him in the care of the Mith Samlanh orphanage at the age of 12. He remained at Mith Samlanh on and off for two years. During this time Young Kor reports that he was temporarily banned from the center, and forced into homelessness five times, all of which were a result of fighting in self defense against the center's "bullies." Eventually Young Kor was permanently banned from Mith Samlanh after stabbing a male staff member's sister in the cheek as revenge against the staff member for his frequent verbal degradation and badgering.

Young Kor was 14 when he became permanently homeless. He hung around with other street kids, many of whom huffed glue and pressured him to try it, telling him "You can fly, and then you can be anywhere you want." Young Kor remarks that as a young child his mother commonly accused him of using drugs, specifically huffing glue. He reasons that he tried it to avoid thinking about family and stress, to forget about his life and to rebel against his mother.

He continued huffing glue regularly until he was 18 and was introduced, by the same group of friends, to heroin and ice. Ice is a form of methamphetamine commonly used in Southeast Asia, which is very similar to its western cousin, crystal meth. Young

Kor has continued actively using all three of these drugs. He also frequently mixes heroin with liquid diazepam before injecting to reduce the cost of the heroin he uses. This is a common practice among injection drug users in Cambodia since the recent increase in drug prices.

Young Kor has remained homeless since he was banned from Mith Samlanh eight years ago. Despite this, he still manages to collect an income considered high by Cambodian standards ($2,700USD per year), where the average annual salary is $360USD. Young Kor makes approximately $3.75USD in tips per day as a parking attendant at a local gas station. He takes in an additional $3.75USD per day for collecting and combining cans and bottles to sell to recycling centers, and selling stolen goods to market vendors.

Young Kor usually spends about $5USD per day on drugs, though he says that three days prior to his interview he started cutting back the amount of heroin he uses in hopes of getting clean.

When he was asked about his reasons for wanting to get clean, he says he is tired of the lifestyle and losing friends to drugs. He has lost ten friends to drugs and drug-related death. Eight of these were a result of overdose. Heroin overdose is a serious problem in Cambodia, due to the lack of resources for drug users, specifically the lack of overdose prevention education and the absence of naloxone (a medication to reverse overdose) in the country.

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Young Kor says that the other two friends he lost were murdered. One of them was being held on drug-related charges in Prsar, a notorious prison in Phnom Penh. Young Kor reports he was beaten to death by the guards in an attempt to implicate others in a false confession.

Since the untimely death of his friends, Young Kor says he has chosen to become more aloof in his relationships and no longer has close friends, only acquaintances. He laughs as he says, "I had a girlfriend, but I took off on her. I only like girls that can feed me and she couldn't."

Young Kor has had his own brushes with death as well. He has overdosed three times, and believes he was revived when locals put lemon juice in his mouth to bring him back to consciousness.

Young Kor was diagnosed with HIV three years ago, and has since been diagnosed with tuberculosis, the most common and fatal opportunistic infection for people with HIV in Cambodia. He has completed the medication regimen for TB but is not taking antiretrovirals. When asked why, he said "I don't want to, I want to let myself go to the gods."

Shortly after his HIV diagnosis, Young Kor was arrested for injecting drugs. Young Kor also has severe asthma and carries an inhaler everywhere he goes. Upon his arrest, the police confiscated his inhaler. At the police station he was hit, kicked, and beaten with sticks by the arresting officers.

Young Kor received a one-day court trial. During his trial he told the judge he wanted to stop using heroin and asked to be placed in a "reeducation camp," as an alternative to jail time. The judge denied his request stating it would be a waste of time for Young Kor to go to detox because he would only relapse when he was released. Young Kor was sentenced to four months in Prsar. He feels that his sentence to prison was an attempt to coerce a false confession to a charge of drug dealing.

Soon after beginning his sentence, Young Kor's asthma began acting up, and only worsened with his heroin withdrawals. He begged the guards for his inhaler. Their response was an uncompassionate "Why did you use drugs in the first place?" He sat in his cell for 10 days having asthma attacks before he was provided with an inhaler. He never received anything to lessen his withdrawal symptoms. He says that he thought he would die in jail.

Following his release from jail, Young Kor returned to his mother's home in Tah Kamao province, in an attempt to stay off drugs. Shortly thereafter he returned to Phnom Penh and relapsed. Since then Young Kor has voluntarily been to and completed detox twice. First he attended an NGO-run program called "Green House." More recently he spent three months in the Cambodian government center called "Oksas Knyom." As he recalls his stays at both, the deep contrasts in the two experiences are evident.

Young Kor reflects upon his stay at Green House. Though bad by international standards, Green House is considered highly humane and cutting edge in Cambodia.

When Young Kor began having withdrawal symptoms there, he received aspirin and was provided with and told to drink liquid glucose. He laughs as he recalls how ineffective the combination was in lessening the physical discomfort of his withdrawal.

During his month-and-a-half stay at Green House, he received some relapse-prevention education. His education consisted of the staff instructing him to find a hobby to occupy his time and help distract him from thinking about drugs. He feels that the staff, had they proper training themselves, would have shared a wealth of information.

Young Kor said he saw a counselor, who was also untrained, but very caring. In his counseling sessions they discussed Young Kor's wishes for the future. They talked about working and finding a job. He was asked how many children he wanted to have and when he would get married. Family is considered one of the most important parts of life in Cam-

bodian culture, and therefore being disowned as a result of their lifestyle is devastating for many drug users.

Young Kor completed the program, but was not provided with any follow-up care or referrals. He feels that, had there been care available, he would have embraced it, but there is no aftercare for drug users in Cambodia. Thus, Young Kor was forced to return to the street empty-handed and began using drugs again the same day.

One year passed before Young Kor decided to give detox another try. During this year Young Kor witnessed the murder of a friend he lovingly refers to as his "street brother." Young Kor was sleeping on the street next to his street brother and was awakened by a group of eight men who told him to get up and walk away quietly. Out of fear, Young Kor did as he was told and the group began maliciously beating his street brother in the face with a 2x4 board and chopping at his limbs with a serrated saw. His friend was brought to a local hospital where he died two weeks later. Young Kor says that the wounds on his street brother were so bad that stitches were impossible because his skin was so torn from the saw that they couldn't find a strong enough place to suture. The effects on Young Kor of witnessing the murder are unmistakable; they are painfully written on his face as he recalls the experience.

Young Kor was fed up with his lifestyle and looked for a way out. He went to Mith Samlanh to speak with someone from their "drug department" to find out what his options were for detox. Mith Samlanh brought him to Oksas Knyom the same day.

Upon his arrival to Oksas Knyom he was searched for money, which would have been stolen by the guards, if he'd had any. He was placed in a 10x20-foot "cell worse than jail" with 36 other men, ages 15 to 35 years old.

Young Kor was kept in this cell 23 hours and 40 minutes a day. He was let out twice a day, ten minutes each time, to shower, use the toilet (as there was not one in the cell), get water and eat. The food provided was a small plastic bag of rice and small amounts of vegetables. He states that if anyone exceeded the ten-minute time limit they were beaten with sticks and kicked by the guards.

When asked if he ever witnessed any physical abuse in detox, Young Kor replies that it was a daily occurrence. One night, he said, he awoke to screams in his cell, where four or five of his cellmates were violently stomping another man to death, his body covered by a blanket. After a few moments, the guards came in, broke it up and removed the lifeless body of the victim, leaving the perpetrators to return to sleep. The only punishment the attackers received was to complete extra chores the following day; one man was forced to sleep outside for a night.

Young Kor stayed to complete the program. As for aftercare, upon his release he was told to "go back to where you came from," which he did. Young Kor never plans to return to Oksas Knyom, although he wishes to get clean and is actively trying to get back into Green House.

Young Kor, now 22 years old, tells me that becoming a better citizen by ending his drug use is first on his list of what he wants in life. Second to that is mending his relationship with his family, as well as starting his own family.

Young Kor is an incredible and optimistic voice for positive change in the lives of Cambodian drug users. He thinks that Oksas Knyom could benefit greatly from capable, educated and compassionate management, and could become truly helpful to Cambodian drug users. Young Kor continually, and forgivingly, recognizes that the lack of education about drugs and HIV causes the majority of the negative stigma surrounding these issues. He hopes that future generations of Cambodians receive proper education so that the change he envisions can be realized for Cambodian society.

Notes

77 A piece of red string that the monks tie on your wrist when you visit a temple. They bless it and it's believed to keep you safe from harm as long as you don't cut it off.

Police detain suspected drug users during the "strike hard" anticrime campaign in the city of Dongguan, China. If registered as a drug user, people may be detained and forcibly tested by the police at any time. Reuters/China Photos

Forced Drug Testing in China: Public Humiliation and a Disruption of Daily Life

The following stories are excerpted from a longer report compiled and published in China by activists in November 2008 called "Drug Users' Urine Testing Stories" (Chengyinzhe de niaojian gushi)

Introduction

In recent years, public security officials in China have expanded the implementation of compulsory urine testing for suspected drug users around the country. The government's 2007 annual national drug prohibition report announced the creation of a web-based data-

Drug users participate in a military-style drill at a compulsory drug treatment center in Kunming. Experts estimate there are as many as 350,000 people detained in China's drug treatment centers. Reinhard Krause/Reuters

base of all registered drug users that would allow government agencies "nationwide information sharing, dynamic monitoring and shadowing, and the creation of a new management and control system for drug users."[78] The new drug laws that came into effect on June 1, 2008 allow for public security officials to enforce compulsory urine testing of suspected drug users. In recent months, drug users in Beijing and Yunnan report that police have resorted to increasingly intrusive ways to find and test people who appear in their system as having used drugs. Facilitated by a system that links registration as a drug user to personal identification cards and that tracks the location of drug users through monitoring the use of these ID cards, police are, with increasing regularity, testing registered drug users who check into hotels or saunas or apply for new government documents. In some cases, those with a history of drug use report that they are apprehended by police, handcuffed, and marched to the police station for testing within hours of checking into hotels while visiting a new city. Those with a history of drug use have been asked to report for urine tests while engaged in ordinary activities of daily life, such as registering their children for school. Police have also reportedly stepped up active patrolling of former drug users, with some individuals reporting being stopped on the street and asked for urine tests several times in a single month. In at least one city, police are asking members of certain minority groups for their identification cards to check whether they appear in the

system as registered drug users before they are allowed to enter the area's most active mosque.

Besides mental anguish, embarrassment, and inconvenience of trips to the police station, the proliferation of testing appears to expand the potential for other types of abuse, including unnecessary and excessive violence against suspected drug users and widespread violations of confidentiality. The following stories, collected from former drug users in several cities by grassroots organizations working to protect the rights of Chinese drug users, provide specific examples of the ways in which these new policies are taking a toll on people attempting to live their lives with dignity. The names of drug users have been changed to protect their identities.

My Understanding of Compulsory Urine Testing

Yu Zhi (female, 25, Yunnan)

Compulsory urine testing sounds harsh, but when it actually happens in real life, it makes people feel quite baffled. What is its purpose? Many people are asked for compulsory urine tests as a result of their participation in activities relating to drug or AIDS prevention work. The test is conducted on a whim, for no reason whatsoever, without any explanation, without any evidence; and, even if the results are negative, you are not allowed to leave; the length of your detainment at the police station is entirely up to the authority's capricious opinion.

The test is conducted on a whim, for no reason whatsoever, without any explanation, without any evidence; and, even if the results are negative, you are not allowed to leave; the length of your detainment at the police station is entirely up to the authority's capricious opinion.

The "People's Republic of China Drug Prohibition Law" clearly states: *The public security division can enact necessary inspections of suspected drug users, and those being inspected must comply.* My understanding of this is as follows: If someone's actions suggest that they are a drug user, then the public security division must amass compelling evidence proving that this person is a suspected drug user, and only then can the public security division enact necessary urine testing.

But in real life, most often this is not the case, and below I will describe a true story of something that happened to close friends. In August 2008, two colleagues were on their way home from work around noon, when they were suddenly surrounded by four or five police officers. They were forcibly brought to the police station for compulsory urine testing. The test results came back negative, but with no explanation my two colleagues were held until after six that evening before they were finally released. These two colleagues ful-

filled their legal requirement: "those being inspected must comply;" though they were taken by officers without cause, they still submitted to the urine testing carried out by the public security division. To them, the whole day of submitting to that process was one of darkness and helplessness.

Currently, law enforcement agencies are calling for legal, upright, strict, and effective execution of the law. If implemented in a respectful and proper fashion, the process of urine testing should allow suspected drug users to request not to have to go to the police office for urine testing. If that is the case, can someone explain what happened to those two colleagues? Can it be that simply because they once used drugs, this sort of coercion is necessary? How, whether a person has committed a crime or not, can his life now still be marred by needing to wear this "hat," forever bearing his mistake, making him submit to these unnecessary and forced requests that can come at any time, in any place?

Many people say that drug users cannot take life positively, but that's exactly what I want to do. I also want to lead a normal life, but every day I have to fear this sort of situation. No matter how long it has been since I quit, this is the type of treatment I have to face.

We are suffering, angry, screaming inside. Where is civility?! Where are human rights?! Where is justice?!

The Difference Between Quitting and Not Quitting Drugs

Li (male, 30, Beijing)

One night in April of 2006, I was bathing with a friend at the bathhouse on a major street in Beijing. As I was resting in the big hall, suddenly many policemen rushed in, running straight for us in a very bad temper. They dragged us to their office, and didn't even let us dress ourselves before we had to go.

Policeman: "Just finished shooting up, huh?"

This time I said, emboldened: "I've quit for a long time!"

Policeman: "Who are you trying to fool? Can anyone quit such things? You'll tell the truth once we're back at the office!"

We tried to object, but no matter what we said they didn't believe us, and so they took us away. Many people were around us, observing, as if we had committed some crime.

By the time we arrived at the police station it was already the early hours of the morning. They separated us and didn't let us use the telephone, but let me drink lots of water and in about an hour we provided urine samples. When the test results came back negative the policemen didn't offer any explanation whatsoever and just let us go.

I angrily asked, "What is the meaning of this?"

A police officer checks a passenger's identification in Guangdong province during an antidrug operation. If registered as a drug user in China's database, people may be marched to the police station and held for hours pending compulsory testing. Reuters/China Photos

But they said, "What of it? Isn't it only natural that you guys should be tested? Or are you expecting us to send you off with a little bow and a ride home?"

The policemen's attitudes were terrible from the beginning. They didn't treat us with an ounce of respect, and even when the test results were negative, their attitudes didn't change a bit. Off drugs or not, such is the case, as if people like us must carry the weight of this charge no matter what we do. Many people say that drug users cannot take life positively, but that's exactly what I want to do. I also want to lead a normal life, but every day I have to fear this sort of situation. No matter how long it has been since I quit, this is the type of treatment I have to face.

How Long Will this Shadow Plague Me?

Wang Wang (female, 40, Yunnan)

To our family, which has experienced much hardship, my daughter's qualification for university renewed a sense of longing and hope for life. From the day that we found out that she had been accepted, I constantly found myself overflowing with the pride of a mother.

However, I would never have thought that immediately after my daughter was accepted, I would bring such humiliation to her, subjecting her to such shame and disgrace in front of many others on my account.

On August 15, 2008, my daughter and her classmate accompanied me to the Public Security Office to process a household registration certificate [identification papers]. On the way my daughter's classmate kept congratulating her, and we entered the branch office, unsuspectingly smiling and chatting all the while. At the office, I explained our purpose to a female officer, who then asked us to wait momentarily. After a while a male and a female officer came in, and the female officer said to me, before my daughter and everyone else present, "Please submit to compulsory urine testing." For someone who originally intended to accompany my daughter to process identification papers, the sudden reversal that now *I* was undergoing urine testing led me to ask in frank surprise: "Why?" The female officer then proceeded to say, "We require urine tests for all you people with a history of drug use that come in to process identification papers."

At the time there were many people present. Even if they wanted me to take a compulsory urine test, does it mean that they have no need to protect my personal privacy? This humiliation of compulsory urine testing after quitting drugs has virtually destroyed the happy relationship that I had with my daughter.

Everyone else there handling their own business, my own daughter, my daughter's classmate—all their eyes were fixed on me, some filled with disdain, others with shock. Especially my daughter, whose face had now paled to sickly green and white. In that moment, I felt the ground give way below me, for my period of drug use had been very short, and very few people even knew about it. Now everything was ruined, especially for my daughter, for how was she to face her classmate after this? At the time, I didn't even know how it was that I followed the female officer into the restroom, or how I came back out.

Back at home, gloominess, pain, and guilt all knotted together inside me. One misstep leads to everlasting strife! I flipped open the drug prohibition law, and saw that Section 32 states the following: *The public security division can enact necessary inspections of suspected drug users, and those being inspected must comply…"* I could not help but ask myself: Yes, the public security division can enact necessary inspections of suspected drug users, but I had gone to help my daughter process her identification papers! What was the basis of suspicion? Can it be that the police could simply take my history of drug use and use it as evidence, and thus require me to take a compulsory urine test? Furthermore, at the

time there were many people present. Even if they wanted me to take a compulsory urine test, does it mean that they have no need to protect my personal privacy?

This humiliation of compulsory urine testing after quitting drugs has virtually destroyed the happy relationship that I had with my daughter. I think back to that moment, to the suspicion, sadness, and disappointment in my daughter's eyes; I think back to my return from the compulsory drug rehabilitation center, when I talked unreservedly with my daughter; I think back to the promise that I made to her then. I was so scared, but after my fears had abated and things were well with my daughter again, such an incident had to happen. Thankfully, the urine testing proved my innocence, and thankfully my daughter understood that I have devoted myself to the work of harm reduction and AIDS prevention and treatment. However, I still worry about what would happen if one day I take medicine because I am sick, and the medicine happens to contain an opiate? What if I once again find myself in such a situation of humiliation and helplessness? This trip with my daughter to the public security office has left a deep, deep shadow on my wound that had been slowly recovering. Who knows how long this shadow will plague me?

We'll Never be Looked at with Anything but Contempt

Compiled by Yu, as told by Ran (male, 40, Beijing)

On July 10, Ran, a drug addict, didn't return home because he had stayed out late drinking with friends. That night, he stayed at a hotel in a district far from the center of town. Nothing happened that night, but the next morning around 9 a.m. some policemen and security guards came to the hotel and upon entering they asked Ran his name, forced him into the squad car, and drove him to the police station. The police officer began his interrogation with the question, "Why didn't you go home last night?"

Ran's response: "Last night I stayed out too late drinking with friends, so I didn't go home."

After the policeman finished asking questions he ceased paying attention to Ran. Ran himself asked for a urine test, but the policeman said, "Wait a while first." Ran was then locked in a small cell, where he waited for an entire morning.

Finally, Ran had no choice but to ask the security guard, "I don't know why this is taking so long, but I'd like to make a phone call."

They were unwilling to grant the request, and furthermore had really bad attitudes about it. Ran even told the policemen that he had been taking methadone, and the office manager of the clinic where he received treatment had called to testify to this, but the policemen still wouldn't listen.

After a very long time, a policeman finally came in and said, very severely: "Don't say a thing. We'll do a urine test and then wait for the results."

It wasn't long before the results came out, and they were negative. But the policeman said in a very ironic tone, "So you're fine—what a novelty! To think, that even you people can quit."

Ran didn't say anything more, but after feeling very uneasy he finally couldn't hold back any longer and said just one thing, "My entry into methadone treatment was also arranged by public security personnel."

Yet the policeman said, still in a bad temper, "What does it matter that it was arranged by the public security? You couldn't quit no matter who arranged it for you." After hearing this, Ran understood that it was useless to try to explain any further.

Not long after, they finally let Ran go. While I was consoling him, Ran said to me, "Don't worry about it! Shoot, I'm already used to it! For people like us, it doesn't even matter whether or not we've quit, we'll never be looked at with anything but contempt!"

The Past is not My Present, Much Less My Future

Li Zhang (male, 40, Yunnan)

Not long ago, I browsed through the blog of a colleague in Beijing who, like me, has used drugs before. I still can't guess how deep her misery is from when the Beijing police forced her to undergo urine testing. After having gone through tonight's compulsory urine test, I thought of many, many past drug addicts who have gone through the humiliation of compulsory urine testing, and felt for them the sympathy of a fellow sufferer.

I read again Section 32 of the Drug Prohibition Law. I discovered a problem here, in the following statement: *The public security division can enact necessary inspections of suspected drug users*. What is the basis of "suspected?" No matter what, suspicion can't simply be based on the past, but in reality the police are doing precisely that, basing their suspicion on a drug user's past record, when they force us to undergo urine testing. I can't help but ask myself, is my present the same as my past? The past is *not* my present, much less my future! I think that when our country and government set laws, the laws need to be more explicit, especially in detailing the basis for suspecting someone of drug use.

In the past five years of talking with others about the nightmarish days of my past drug use, I feel so much self-blame and regret. But a friend of mine always responds with a smile: past drug use is like a child who is just learning to walk. After falling down once, the important thing is that you can now pick yourself back up! I know that my friend is trying to give me comforting advice, and I know that getting over past drug use is definitely not as easy or relaxed as her words make it seem. I know this, so now I'm trying all the harder, in the hopes that my life will return to the peace and calm that it was before this experience of drugs. But because of that unbearably awful past, my life will never return

to that time of peace and calm that I yearn for. Perhaps in the future I will need to wear a scroll on my head for a whole day that reads, "I have used drugs before, please make me take a urine test!"

Legal Testimony (June 4, 2008)

Liu Zhi (male, 34, Yunnan)

The defendant and his friend were traveling through Beijing from Yunnan province. A little after three in the afternoon, the two of them checked into a hotel in a densely populated district in Beijing. The morning of June 5, the defendant and his friend went out to have fun at Tiananmen and came back to the hotel in the afternoon. At around 3 p.m., four people came to the room in which the defendant was staying, three of whom were wearing police uniforms. Immediately upon entering the room, the four snapped handcuffs on the defendant and his friend, and then immediately proceeded to search their backpacks and belongings. The police officer without a uniform took the defendant and his friend to an adjacent room, interrogating them for some details, such as their purpose in Beijing, whether they were currently using drugs, etc. After several minutes, the policemen took the defendant and his friend out of the hotel and pushed them into police cars. Throughout this entire process, the policemen never showed documents or papers to identify themselves. It was only when the defendant was in the police car and he asked them who they were, that they finally answered that they were from the nearest Beijing district's police office.

The defendant and his friend were taken to a local police station and were separated once they got there. The police asked the defendant whether he had a history of drug use, and whether he was currently using drugs. The defendant answered that he had used drugs in the past but was no longer doing so. Afterward, the two were subjected to physical examinations for the presence of drugs, and the results were negative. A record was made of this and the two men signed a summons citation. The police let the defendant and his friend leave the police station on their own.

The defendant believes that in the process of administering the law, the police officers infringed on his personal rights.

Notes

78 People's Republic of China 2007 Annual Drug Prohibition Report. Issued by the Office of National Committee of Drug Prohibition, editor Yang Fengrui (2007 Nian Zhongguo Jindu Baogao, Zhongguo Guoaji Jindu Weiyuanhiu Banggongshi). Accessed: http://cn.chinagate.com.cn/reports/2007-06/07/content_8358437_5.htm.

A drug user sits with his legs chained inside a "rehabilitation" center run by a faith-based organization in Churachandpur district, Manipur state. His ankles are bandaged because of wounds caused by the chains. Courtesy of Northeast India Harm Reduction Network

Drug Control Policies and HIV Prevention and Care Among Injection Drug Users in Imphal, India

Dr. Venkatesan Chakrapani, M.D. and Mr. Kh. Jayanta Kumar[79]
Indian Network for People Living with HIV (INP+)

Introduction

Manipur is one of the states worst affected by the HIV epidemic in northeast India. Manipur lies adjacent to the "golden triangle," the area where Myanmar, Laos, and Thailand meet, and a major center of opium production. Thus, injection and non-injection illicit drugs are commonly available in Manipur.

In 1998, the estimated number of injection drug users in Manipur was 15,000-20,000.[80] Though HIV prevalence among IDUs has decreased from about 70 percent in the early 1990s[81,82] to 19.8 percent in 2006,[83] studies have shown very high risk behaviors among IDUs in Manipur, with more than 90 percent sharing needles and equipment.[84] As of April 2006, there were 22,857 HIV-positive cases reported in Manipur; of these, 49 percent were categorized as having contracted HIV through injection drug use.[85] Also, HIV-positive IDUs in Manipur have a very high prevalence of hepatitis B virus (100 percent) and hepatitis C virus (92-98 percent).[86]

In Imphal, several law enforcement agencies are present: police, military, and paramilitary forces such as the "Assam rifles."[87] Insurgency movements and a "cold war" among the different ethnic groups intermittently erupt in violent clashes. Thirty-nine armed militant outfits are operating in Manipur state, which has a population of less than 2.6 million.[88] Fights between the government and these militant groups (despite the "suspension of operations" or ceasefire agreements), and ethnic conflicts that have been present in the region for many years, have led to strict law enforcement by police and a strong army presence in Manipur.[89]

In India, both illicit drug users and illicit drug dealers are penalized. In 1985, comprehensive legislation, the Narcotic Drugs and Psychotropic Substances (NDPS) Act replaced the previous three acts—the Opium Acts of 1857 and 1878, and the Dangerous Drugs Act of 1930. The NDPS Act has been amended twice—in 1989 and 2001, giving more power to the police in terms of illicit drug-related arrests and raids. According to the NDPS Act, a drug user found guilty of possessing a small quantity of a drug is liable for six months of imprisonment. If he is found guilty of consumption, he could be sentenced to either six months or one year in prison, depending on the substance consumed.[90]

While not using the NDPS Act *per se*, there are reports from major cities in India that police interfere with HIV prevention activities among drug users.[91] Though this is common knowledge, there has been limited documentation of police interference in HIV prevention and care programs among IDUs in Manipur. Thus, our study objective was to explore the effects of the actions of law enforcement agencies (most notably, police activities) on access to and utilization of HIV prevention and treatment services for IDUs in Imphal in order to devise appropriate structural level interventions to improve their quality of life.

Methodology

This qualitative study was implemented with active collaboration of nongovernmental organizations in Imphal city in Manipur state in northeast India. Four focus groups and four key informant interviews were conducted.

Purposive sampling was used to recruit the study participants for focus group discussions. All recruitment was conducted by word of mouth only, in order to avoid potential

Operational definitions of terms used

Drug control policies/laws: The aggregate of policies designed to affect the supply and/or demand for illicit drugs locally or internationally. Drug policy covers a range of strategies on such issues as education, treatment, drug laws, policing, and border surveillance.

Law enforcement agencies (in Imphal): Police, police commandos, army (military), and paramilitary forces. (Police commandos are specialized police forces trained in guerilla warfare to tackle militant groups. Army and paramilitary forces such as Assam rifles, Indian Reserve Battalion, and Central Reserve Police Force all carry out counter-insurgency activities.)

HIV prevention and treatment, care, and support services for IDUs: Outreach education; needle and syringe exchange programs; oral substitution treatment (sublingual buprenorphine); antiretroviral treatment and treatment of opportunistic infections for HIV-positive IDUs; drug-dependence treatment and rehabilitation programs; abscess management; screening/treatment of partners; and treatment for co-infections (sexually transmitted infections, hepatitis, etc.).

risks to participants. Sociodemographic questions were asked of all participants. These included questions about age, level of education, occupation, marital status, current drug use status, and living arrangements.

A total of four focus groups were conducted among the following groups:[92]

1. Male IDUs who are outreach workers of NGOs serving IDUs
2. Male IDUs who had faced problems from law enforcement agencies[93]
3. Male IDUs who had been incarcerated
4. Female IDUs who also engage in sex work

Four key informants were interviewed: a retired high-ranking police official, the program manager of an NGO working for IDUs, the director of an NGO working for female IDUs; and a drug dealer.

Focus group venues were chosen for their convenience to participants and to ensure the safety of participants and research staff. The study received ethics approval from the ethics committee constituted by INP+.

Focus groups and key informant interviews were conducted using a semi-structured in-depth interview guide in Manipuri (the local language in Manipur) with scripted probes. Questions were modified or added over the course of the study in an iterative process to explore and reflect on emerging findings, a technique called progressive focusing.[94] Focus group facilitators and interviewers were native Manipuri-language speakers who also communicate well in English. All interviews and communications with participants were conducted in Manipuri, though some key informants and focus group participants also often used English sentences and words.

The duration of focus groups ranged from 60 to 120 minutes and key informant interviews lasted approximately 45 minutes. An honorarium of 250 Indian rupees (about $7 USD) was given to the study participants who attended focus groups. Key informants did not receive honoraria. Interviews were tape-recorded and transcribed verbatim in Manipuri and translated into English for data analysis.

Multiple readings of the transcripts were performed by two independent investigators. Line-by-line review of the transcripts was conducted and first-level codes, which are descriptors of important components of the focus groups and interviews, including in vivo codes, were noted in the margins.[95,96] Next, text corresponding to each of the first-level codes was reviewed by at least two investigators. Using focused coding and a constant comparative method,[97,98] first-level codes were refined and organized into categories. Finally, theoretical coding was undertaken to identify higher-level codes, relationships among categories, and to ensure saturation of categories.[99] "Member checking" (respondent validation) with key informants and peer debriefing[100] were undertaken with community leaders to increase trustworthiness of the findings. The results correspond to the emergent categories; all quotations are drawn from the focus groups and key informant interviews.

Characteristics of the participants

A total of 33 people (23 men and 10 women) participated in the four focus groups.

Among male IDUs (n=23), ages ranged from 24 to 40 years, with a mean of 33.6 years. About 43 percent (n=10/23) had completed higher secondary education and 35 percent (n=8/23) had completed an undergraduate degree. More than half (52 percent; n=12) were unemployed and 43 percent (n=10/23) were working for a voluntary organization serving IDUs. About 70 percent (n=16/23) were never married. Only 13 percent (n=3/23) were current drug users.

The age of female IDUs (n=10) ranged from 22 to 40 years, with a mean of 30.7 years. Sixty percent (n=6/10) hadn't completed high school. Seventy percent (n=7/10) were never married and the same proportion (n=7/10) was currently injecting drugs.

Key findings & discussion

Drug users in Imphal have a high likelihood of being stopped, searched, and detained because of security concerns related to the insurgency. Both police and military have the power to stop and search anyone whom they suspect as a drug user or insurgent. They also perform "routine random checks." Focus group participants report that frisking is more common if a person appears frail, has multiple scars, or is a regular at a drug hotspot.

Both police and the army can arrest people in relation to drugs, but the army is required to hand over those persons to the nearby police station. A key informant pointed out that while there is no difference in punishment for drug users who are caught for the first time or the second time, drug dealers are punished with increasing severity for each subsequent arrest.

One key informant stated, "Whatever drugs seized by law enforcement agencies are in small quantity and are basically meant for personal consumption." Frequent raids and frisking of people to find out whether they carry drugs may reveal small amounts of drugs for personal consumption, while large quantities of drugs that are smuggled through the national highway that passes through Imphal to Kolkata and then Delhi are not caught.

Frequent raids and frisking of people to find out whether they carry drugs may reveal small amounts of drugs for personal consumption, while large quantities of drugs that are smuggled through the national highway that passes through Imphal to Kolkata and then Delhi are not caught.

The same key informant argued that police should only focus on supply reduction, while NGOs can focus on demand reduction. However, participants described several instances of being exploited by the police:

- Drug dealers need to periodically give "tax"—a term used by local people to refer to paying bribes to police on a regular basis.
- Police often raid the places/rooms where female IDU sex workers work. If they find syringes, they beat and forcibly take money from the sex workers. They also force them to divulge where they bought their drugs, and beat them if they refuse. Dealers may later refuse to sell them drugs, because they blame them for "outing" them to police.
- Female IDU sex workers and male IDUs are often not remanded or arrested but police ask them to pay a particular amount of money in exchange for not filing a case against them. Many also routinely pay bribes to police.

Though supply reduction is supposed to be the main motivation behind police actions, participants' accounts strongly suggest that money is often the prime motivation. After frisking a suspect, if police do not find drugs, syringes, or money on an IDU, they might offer some drugs in exchange for exposing drug dealers or other drug users. In turn, police extort money from people IDUs identify as drug dealers or drug users.

Ways that police actions interfere with HIV prevention and care services to IDUs

DRUG USERS FACE PROBLEMS WHEN CARRYING SYRINGES

Because of the "stop-search" tactics adopted by police, IDUs are afraid to carry clean syringes, since that would constitute evidence of drug use (while carrying a syringe is not in itself illegal, carrying syringes in addition to small quantities of drugs for personal consumption constitutes additional evidence). Because IDUs are afraid to carry unclean syringes for exchange, the needle and syringe exchange program in Imphal has in essence become just a "needle and syringe *supply* program." As a key informant questioned, "If they cannot even carry clean syringes how can you expect them to carry used syringes for exchange?" Difficulty in carrying clean or unclean syringes means increased likelihood of needle sharing and lack of safe disposal of unclean syringes. As a participant said, "When we [inject] drugs we need to be quick. Police might come at any time. For that reason....we don't mind sharing with others. Sometimes we go to the hills to avoid police."

Difficulty in carrying clean or unclean syringes means increased likelihood of needle sharing and lack of safe disposal of unclean syringes.

POLICE APPREHEND IDUS AS THEY LEAVE NGO DROP-IN CENTERS THAT OPERATE NEEDLE AND SYRINGE PROGRAMS

Participants narrated incidents of police waiting outside drop-in centers to catch IDUs "red-handed" with syringes and then extort money from them. Destruction of syringes, though rare, is not unheard of, especially if IDUs do not have money to pay off the police. Police may detain those persons who do not have money. As a participant shared: "Be it [outreach] staff, or customer or client, if they find them with syringe, they always take advantage [demand money]. Even if we do not have money, they made us mortgage our things, be it cycle or whatever and take the money." Even those who are found with drugs may not be arrested if they can get money to pay off the authorities. As narrated by one participant:

> "It was in [a place] that I went with a friend of mine to get SP [spasmoproxyvon]. When we returned, there was a combined team of IRB [Indian Reserve Battalion] and commandos and they stopped us. They searched us and when they found the stuff [drugs] they beat us at first, then they checked if we had money with us and they even mortgaged our vehicle in that area. We went back and got it [the vehicle] back by paying money. They did all this for money only. They did not take us properly to the police station but released us on the way."

Used syringes impale a tree in Churachandpur district, Manipur state. Drug users are reluctant to carry syringes due to the "stop-search" tactics used by the police, and instead choose to dispose of them in other ways. Deshakalyan Chowdhury/AFP/Getty Images

Sometimes police take drug users to their quarters and drug users are asked to clean their rooms and wash their clothes (no money is paid to drug users for these services). Because of these experiences, IDUs are hesitant to come to drop-in centers and collect clean syringes. Though NGOs have negotiated agreements with police not to enter their premises, they have not been able to stop police from apprehending IDUs outside their premises.

One key informant, a former police official in Imphal, acknowledged that police do take bribes from drug users, but denied that police target IDUs visiting drop-in centers: "We do not target drop-in centers [for IDUs]... Most of the [police] officers at the higher level have understood the [needle exchange] program very well but there is still a lack of understanding at the ground level [policemen at the lower rungs]...sometimes police take 10 or 20 [Indian] rupees from people who carry syringes."

Though drugs are available in prisons, clean syringes are not available, resulting in up to 30 inmates sharing a single syringe.

DETENTION/ARREST OF DRUG USERS BUT NO DRUG/INFECTION-RELATED REFERRAL SERVICES

IDUs who are detained for questioning, or who are arrested for drug-related or other criminal charges, are usually not referred to drug-related or infection-related prevention and treatment services. Withdrawal symptoms faced by IDUs during detention are not attended to. Though drugs are available in prisons, clean syringes are not available, resulting in up to 30 inmates sharing a single syringe. There are no needle and syringe programs within prisons and there are limited or no outside referrals to access drug-related or infection-related services. Key informants reported that even after release from prisons, IDUs are not connected to prevention or treatment services. When asked about what happens after a drug user is released from prison, participants said that they are "left on their own" and no mechanisms exist to connect them to agencies providing harm reduction or drug dependence treatment services.

HARASSMENT OF PEER EDUCATORS AND OUTREACH STAFF

Participants reported that police do not recognize the NGO identity cards issued to the field staff (peer educators and outreach workers), and the police often verbally abuse the workers. Police do not treat outreach workers who are ex-users themselves with dignity, and instead see them only as drug users.

Antidrug user organizations in Manipur partially tonsure suspected drug users to publicly identify and humiliate them. Courtesy of Northeast India Harm Reduction Network

Consequences of police actions

Common consequences arising from police actions include:

- Frequent frisking and increased risk of arrest if found with syringes means IDUs are not likely to carry clean syringes or bring used syringes for needle exchange.
- After being caught outside drop-in centers, IDUs are reluctant to return to NGOs to utilize the available services. Thus, many months and years of rapport built with IDUs are undone because of arrests near service providing centers.
- Police extortion of drug users causes some IDUs to commit theft to get the money necessary for drugs and everyday expenses. IDUs are sometimes forced to go underground, so that even experienced NGOs find it difficult to trace them in order to provide the necessary services.
- Female sex workers who are IDUs regularly pay bribes to the police and thus are forced to take on more clients to earn more money, and sometimes do not insist on condom use by their clients (as this usually means they will be paid more).
- To avoid police exploitation, drug users adopt a variety of strategies, including injecting in sites such as the neck or other areas where scars are not as visible. Injecting in the neck can be dangerous due to the likelihood of hitting an artery or a nerve.
- Police harassment of outreach workers results in a high turnover of staff; this affects the quality of outreach work.

- Sending drug users to prison, where there is no provision of clean injecting equipment, leads to increased risk of HIV and hepatitis C.

Misconceptions among law enforcement officials

An interview with a key informant who was a former police official as well as a former jail warden revealed perspectives from law enforcers that have implications for involving police in harm reduction, demand reduction, and providing services inside prisons. Misconceptions may include:

- The assumption that NGOs working among IDUs are operating for profit. Hence, police may not want to cooperate in programs that NGOs organize for them.
- The expectation that the state government will introduce prevention and treatment services for IDUs within prisons, as this is not seen as the responsibility of the prison authorities.
- The lack of belief that drug addiction is a disease, or that drug users need treatment rather than punishment.
- Not seeing any role for police in HIV prevention since their role is "supply reduction" and not "demand reduction." Even if they want to, they think their heavy workload precludes them from engaging in demand reduction or harm reduction activities.
- Though higher police officials have made public statements in the media that IDUs carrying syringes will not be arrested for the mere possession of clean syringes/needles, at the ground level, police still routinely frisk and extort money from IDUs. Participants felt that this disconnect could be because of the lack of training of lower-grade police *sepoys* (constables) about drug-related issues and HIV prevention and care.

Actions taken to sensitize police

DIRECT ADVOCACY WITH RESPECTIVE POLICE STATION

Representatives from NGOs working with women approach police stations where women are placed in custody and talk to them about the HIV prevention work being done among sex workers and IDUs, and educate them about the harm reduction principles and human rights of sex workers. Subsequently, these police are usually supportive. A key informant, however, said that because of frequent transfers of police personnel, these direct advocacy actions alone are insufficient.

SENSITIZATION PROGRAMS FOR POLICE PERSONNEL

Key informants mentioned that the Manipur State AIDS Control Society, which oversees HIV/AIDS programs in Manipur, has conducted some sensitization programs for police in Imphal but not all NGOs working with IDUs were involved in those programs. Thus, those NGOs did not benefit, and police officers continue to interfere with HIV prevention activities. According to some key informants, NGOs do not typically initiate or conduct such sensitization programs for police, possibly because of lack of funding support and the bureaucracy involved in getting permission for such programs.

"Antidrug" groups and "pressure groups": Interference in HIV prevention and care programs among IDUs

Because Manipur lies near the "golden triangle," illicit drugs are widely available. This has led to the formation of many "antidrug" organizations in Manipur, which, rather than focusing on drug abuse prevention, seem to target injection drug users; one key informant commented that they are really "antidrug user" organizations.

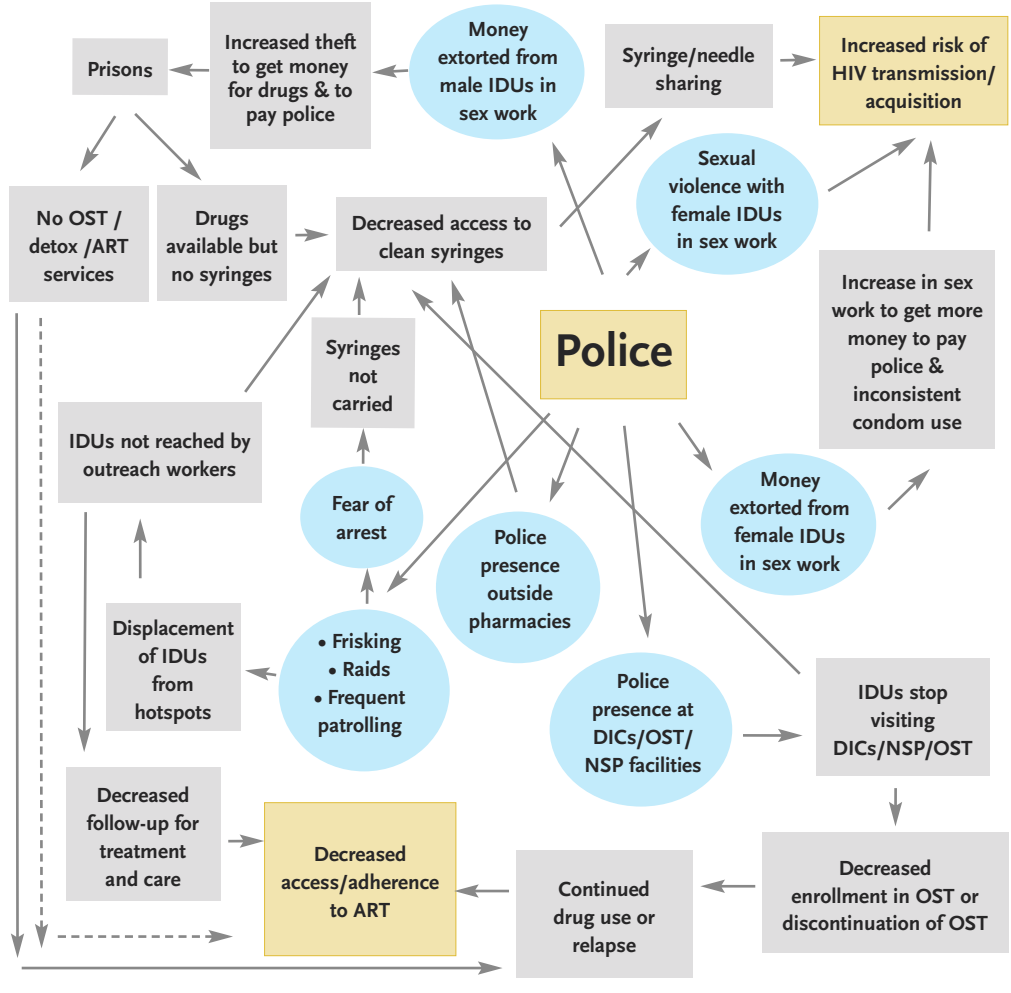
Until recently, and even occasionally today, it was not uncommon to find these groups punishing drug users—by shooting them in the legs, or publicly humiliating drug users by shaving their heads, forcing them to carry a board that says "I am a drug user," and shaving one side of their moustache. Key informants said that these activities continue even now, though sporadically. Some "antidrug" agencies confine female IDUs, including those who engage in sex work, and release them only after repeated requests from NGOs that work with sex workers. A key informant relayed how her organization was threatened by "antidrug" agencies. She said, "[An antidrug agency] called me and said, 'Why are you giving condoms to these women [in sex work]? Do you want action to be taken against you and your agency?'" She said that she was seriously considering quitting social work, as she could no longer take these periodic threats.

Harm reduction and HIV services inside prisons

Participants said that many drug users end up in prison due to a variety of reasons, but commonly because family members report them to police who in turn arrest them under false charges (usually theft) and put them in jail. Or drug users may steal from their own family members, neighbors, or other people in order to purchase drugs. On rare occasions, IDUs are sent to jail for possession of drugs and syringes.

Drugs are freely available inside prisons according to many participants who had been to prison and key informants. Focus group participants explained that drugs enter the prison through several routes—even through the "Hazoor" (literally means "sir;" in this context, the term refers to head of a particular section in a prison). Though drugs are readily available in prison, syringes are not. One syringe costs about five Indian rupees

Chart B. Police interference in HIV prevention & treatment for IDUs in Imphal (Venkatesan Chakrapani & Bobby Jayanta)



outside prison, but costs 100 to 200 rupees inside prison, since syringes are difficult to bring inside prison in sufficient quantities. Hence, many IDUs in prison share syringes.

Inside the police lock-up as well as prisons, there are no medical facilities or any medical assistance to help drug users experiencing withdrawal. When asked about what treatment is available for someone experiencing withdrawal symptoms, one of the participants said with a smile, "The stick is the treatment." Policemen beat the person who is experiencing withdrawal symptoms with a stick (called a "lathi"). However, because of the

availability of drugs inside prisons, other prison inmates may share drugs (heroin or oral drugs) with the person experiencing withdrawal symptoms to reduce the severity.

Drug users may sometimes come across sensitive doctors in prison medical facilities who agree to prescribe them painkillers to alleviate the physical pain of withdrawal. However, many doctors do not prescribe painkillers because they are concerned about "diversion" of drugs (into injection use). Even if someone is known to be HIV-positive and has symptoms, referral to appropriate treatment outside the prison is unlikely.

When asked about what treatment is available for someone experiencing withdrawal symptoms, one of the participants said with a smile, "The stick is the treatment."

Antiretroviral treatment (ART) is not available inside prisons. Some family members manage to get antiretroviral medicines from government hospitals and give it to the prisoners, somehow bypassing the current government guidelines that antiretrovirals can be given only to patients when they come for the monthly check-up in the government ART centers. Participants who had been to prisons said that HIV-positive inmates face difficulties in getting ART because of the bureaucratic process involved in getting approval for going to government ART centers. Even when prisoners get the necessary approval, because of the lack of adequate security staff to accompany the prisoner(s), people living with HIV get ART only after considerable delay or receive ART only on an intermittent basis, which affects treatment adherence and efficacy.

Recommendations

a. Train/sensitize police on harm reduction and human rights of drug users:

Harm reduction and human rights training for police is required throughout the state of Manipur and should not be limited to the project areas of organizations implementing HIV prevention and care programs for IDUs. Police cadres at all levels need to be trained—including police at the lower rungs, since they encounter people who use drugs face-to-face. Police should also be educated about the need to refer IDUs who are arrested or remanded to harm reduction and rehabilitation centers.

b. Sensitize the general public to decrease societal stigma/discrimination against people who use drugs:

Create awareness among the general public about drug users' human rights and the need for humane drug treatment.

c. Create partnerships between law enforcement agencies and the public health sector:

Establish joint action teams that comprise local health authorities including the Department of Health, Manipur State AIDS Control Society and Department of Social Welfare, and law enforcement agencies to work on reducing drug-related crime and the supply of illegal drugs, without interfering with effective drug treatment and harm reduction programs for IDUs.

d. Police should exercise discretion in implementing drug-related laws/policies:

Rather than arresting IDUs or confiscating their injecting equipment, police should warn and refer drug users to appropriate health and social services. Directives from higher levels should be effectively communicated to police on the street.

e. In prisons, introduce harm reduction services and ensure treatment for people living with HIV:

There is an urgent need to introduce harm reduction services such as needle and syringe exchange programs, medication assisted treatment, and detoxification in prison settings. Prevention education on HIV and hepatitis and linkages with treatment for these infections are crucial. Proper linkages with prevention and treatment services need to be ensured after IDUs are released from prisons.

Notes

79 We thank all the study participants for openly sharing their experiences and perspectives. Thanks to Dr. Ram Kamei and Ms. Hoineilam Kipgen for assisting in data collection, and in transcription and translation of the focus groups and interviews. We thank INP+ board members for their guidance and suggestions in successfully completing this study.

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Section II
Superpower Influence: The Export of Russian and American Approaches

Russian president Vladimir Putin and Tajik president Imomali Rakhmonov discuss a proposal to create an antidrug coalition to fight drug smuggling. Tajikistan has adopted many of Russia's stringent drug policies. Reuters POOL/New

Effects of UN and Russian Influence on Drug Policy in Central Asia

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Introduction

The UN drug control conventions and the 1998 UNGASS commitments are often used to justify prohibitionist and punitive drug policies employed by national governments in Eurasia.[101] In the Russian Federation and the Central Asian countries, efforts to reduce drug demand have been conceived largely through the lens of enforcing criminal prohibitions on drugs, and have also led to coercive drug dependence treatment, raising serious human rights concerns.[102] Drug user registries and limitations of the rights of those who are registered as drug users are in place in each of these countries. Studies done in some

countries in the region have reported that drug dependence treatment options in place are often ineffective.[103] Meanwhile, as of this writing, an evidence-based intervention, the use of opioid substitution treatment (e.g., methadone and buprenorphine), is not yet implemented in some countries (e.g., Tajikistan and Kazakhstan), exists only as small-scale pilot projects in others (e.g., Uzbekistan), and in the case of Russia, remains criminally prohibited.[104] There are numerous reports of widespread human rights violations against people who use drugs in countries that are members of the Commonwealth of Independent States (CIS), comprising 12 former Soviet republics. These abuses include police harassment and targeting of people who use drugs in order to meet arrest quotas.[105]

The Conventions have often been misinterpreted, whether deliberately or inadvertently, as prohibiting various evidence-based measures to reduce the harms associated with drug use—such as opioid substitution treatment, needle and syringe exchange and supervised drug consumption sites—notwithstanding the clear conclusions reached by the legal advisers of the UN drug control program that such interventions are permissible under the Conventions.[106] As a number of commentators have highlighted:

> The ideal of a "drug free world" (to quote from the declaration adopted by the UN General Assembly in 1998), and its required prohibitionist, punitive approach, may be based on an overarching concern for the "health and welfare of mankind." But in practice, the health and welfare of those in need of special care and assistance—people who use drugs, those most at risk from drug-related harm, and the most marginalized communities—have not been a priority. They have instead been overshadowed, and often badly damaged, by the pursuit of that drug-free ideal.[107]

Against this backdrop of global and regional concern, in this essay we analyze the role of the predominantly prohibitionist approach embodied in the UN drug control conventions and the 1998 Political Declaration in shaping Russian drug legislation and policy, and its influence on drug policy in the Central Asian countries of Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan. Our analysis proceeds in a number of stages following this introduction.

The first part of this essay provides context by outlining the epidemiological shifts in injection drug use and the HIV epidemic in Russia and Central Asia over the last decade since the 1998 UNGASS on the World Drug Problem, which reveals that these intertwined epidemics have worsened, with injection drug use functioning as a major driver of the HIV epidemic.

The second part analyzes the role played by the UN drug control framework, as reaffirmed by the 1998 UNGASS Political Declaration, in Russia's "war on drugs." However, given Russia's dominance in the region, its influence is felt well beyond its borders.

The third part therefore analyzes regional cooperation on drug control, with a focus on the two model laws on drugs adopted by the Inter-Parliamentary Assembly of the Commonwealth of Independent States (CIS), which largely replicate Russian policy.

In the fourth part, a brief analysis of national drug laws in the Central Asian countries (Kazakhstan, Kyrgyzstan, Uzbekistan, and Tajikistan) suggests that, despite Russia's apparent intention, the CIS model laws have not had a major influence on national legislation in at least these CIS member states. Rather, the CIS and other regional bodies serve primarily as fora for regular rhetorical reinforcement of the "war on drugs." However, Russian law has clearly been exported as a model and has had some impact. We consider the national approach to drugs in the four Central Asian countries that are members of the CIS, and trace similarities between their approaches to drug control. For many political and historical reasons—such as their common Soviet past, the economic and political influence of Russia, and limited independent national expertise and access to independent information accessible in Russian or local languages—the Central Asian countries have adopted drug laws very similar to those of Russia. Yet this is only part of the story. Despite certain legislative similarities to Russia, and the Central Asian countries' rhetorical support for the "war on drugs" promoted by Russia (with frequent reference to the UN drug control documents), including through regional bodies and cooperation agreements, several of the countries have in recent years shown, in at least some areas, growing willingness to pursue independent policies shaped by the local situation and circumstances.

Finally, the fifth part concludes by identifying a number of reforms that could and should be implemented by the governments of Russia and the Central Asian countries to use the flexibilities afforded by the UN drug control conventions so as to adopt a more sophisticated and balanced approach to drug use. This approach should take into account concerns about the human rights and public health consequences of an overly strict adherence to prohibition, including the spread of HIV and hepatitis C virus (HCV), and expand evidence-based, human rights-based measures to prevent and reduce harms associated with problematic drug use.

Injection drug use and HIV in Russia and Central Asia

The Russian Federation and the Central Asian countries formerly part of the Soviet Union currently maintain repressive laws and policies on illicit drugs, in line with the dominant orientation and (perceived) requirements of the UN treaties on drug control. At the same time, these countries report fast-growing epidemics of both HIV and drug use, with all evidence indicating the former is fuelled to a considerable degree by the latter, prompting some Central Asian states to begin the introduction of programs aimed at reducing HIV infection and otherwise protecting the health of people who use drugs. Member States of the Commonwealth of Independent States have recently estimated that the numbers of

people in the region who use illegal drugs and who are dependent on drugs increase by up to 10 percent every year.[108] The UN Office on Drugs and Crime (UNODC), the lead agency of the UN system tasked with combating illicit drugs, crime, and terrorism, also reports that the Central Asian countries are experiencing consistently rising levels of drug use.[109] As shown on Table 2 below, official data from both Russia[110] and four Central Asian countries[111] show that, over the decade since the 1998 UNGASS on the World Drug Problem, there has been a significant increase in the number of drug users listed in those States' registries. Recent reports estimate the real figure of people who inject drugs is many times higher.[112]

Table 2. Injection drug use in Russia and Central Asia

	Number of registered drug users[113]		Estimates of drug use (2008) (among people age 15-64)[114]	
	2000	2007	No. of people injecting drugs	Prevalence of injection drug use
Russia	441,927	537,774	1,825,000	1.78%
Kazakhstan	38,320	55,286	100,000	0.96%
Kyrgyzstan	4,479	8,464	25,000	0.74%
Tajikistan	4,200	8,607	17,000	0.45%
Uzbekistan	14,627	21,465	80,000	0.47%

The region's epidemic of injection drug use is paralleled by some of the fastest-growing HIV epidemics in the world.[115] According to UNODC, the number of officially recorded HIV infections in four Central Asia countries (Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan) increased 15-fold from 2000 to 2007.[116] Table 3 below shows the development of the HIV epidemic in Russia and these countries over the last decade (corresponding almost exactly to the decade since the 1998 UNGASS on Drugs), based on estimates by UNAIDS and the World Health Organization (WHO).

Indeed, the epidemics of injection drug use and HIV are closely intertwined in these countries of the former Soviet Union. While injection drug use accounts for approximately 10 percent of HIV infections globally, in Central Asia and Russia it is associated with a much higher percentage of HIV infections.[117] According to UNAIDS, injection drug use is the main mode of HIV transmission in the Russian Federation,[118] and of the new HIV

Table 3. HIV prevalence in Russia and Central Asia

	1997[119]		2007[120]	
	Adults living with HIV (age 15-49)	Adult HIV prevalence (percent)	Adults living with HIV (age 15+)	Adult HIV prevalence (percent)
Russia	40,000	0.05	940,000	1.1
Kazakhstan	2,500	0.03	12,000	0.1
Kyrgyzstan	<100	<0.005	4,200	0.1
Tajikistan	<100	<0.005	10,000	0.3
Uzbekistan	<100	<0.005	16,000	0.1

cases reported in the region of Eastern Europe and Central Asia in 2006 for which information on the mode of transmission is available, an estimated 62 percent are attributed to injection drug use.[121] The figure is slightly higher in both Russia and Kazakhstan, where injection drug use accounted for approximately two-thirds (66percent) of HIV infections newly reported in 2006.[122] UNODC has estimated that, in 2007, 73 percent of new HIV infections in Kazakhstan were connected with injection drug use (somewhat higher than the UNAIDS estimate), with corresponding figures of 72 percent in Kyrgyzstan, 58 percent in Tajikistan, and 47 percent in Uzbekistan.[123]

In Russia and Central Asia, HIV prevalence is dramatically higher among people who inject drugs than among the population as a whole, and has been estimated as follows: 37.15 percent in Russia; 9.2 percent in Kazakhstan; 8.0 percent in Kyrgyzstan; 14.7 percent in Tajikistan, and 15.6 percent in Uzbekistan.[124] In Uzbekistan, which now has the largest epidemic in Central Asia, the number of newly reported HIV diagnoses rose exponentially between 1999 and 2003 (from 28 to 1,836 cases); the number of registered HIV infections in injection drug users more than doubled between 2002 and 2006 (from 631 to 1,454); and almost one in three (30 percent) injection drug users tested HIV positive in a study in Tashkent between 2003 and 2004.[125] Other Central Asian countries have also seen similar dramatic increases: for example, in a single year, HIV prevalence among injection drug users increased from 16 percent (2005) to 24 percent (2006) in the cities of Dushanbe and Khujand in the Republic of Tajikistan.[126]

A man suffers through unmedicated withdrawal in a narcological clinic in Dushanbe, Tajikistan. Alessandro Scotti/Panos

The UN drug control framework and Russian drug policy

The three UN drug control conventions establish strict measures (prohibition, criminalization, and punishment) in relation to drug possession and the drug trade. The 1961 Single Convention on Narcotic Drugs requires states to limit in their domestic law the production and possession of, and the trade in, scheduled drugs exclusively to medical and scientific purposes.[127] The 1971 Convention on Psychotropic Substances expanded the list of prohibited drugs.[128] The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances added precursors to the list of controlled substances, and expanded the scope of the conventions to include restrictions on demand as well as supply.[129] States parties to the 1988 convention are required to make it a criminal offense to intentionally "possess, purchase or cultivate narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 convention, the 1961 convention as amended or the 1971 convention."[130] In addition, under the 1988 convention, each state party must, subject to its "constitutional principles and the basic concepts of its legal system," make it a crime for someone to publicly incite or induce others to use illicit drugs.

As analysts point out, however, the language of the conventions is flexible enough to accommodate a range of responses to illicit drugs and to allow countries to tailor their responses to national realities.[131] While both the 1961 and 1971 conventions require that parties act to discourage drug use, they also oblige states parties to take all practicable measures "for the early identification, treatment, education, aftercare, rehabilitation, and social integration" of those who use illicit drugs.[132] The 1988 convention underlines the primacy of efforts to minimize human suffering related to drug use, and further reiterates

that treatment, education, aftercare, and rehabilitation are acceptable alternatives to criminal conviction and punishment in the case of possession, purchase, or cultivation for personal consumption that is contrary to the provisions of the 1961 and 1971 conventions.[133] At the 1998 UNGASS on Drugs, UN member states unanimously declared that demand reduction policies should aim not only at "preventing the use of drugs" but also at "reducing the adverse consequences of drug abuse."[134]

It is because of such provisions in the conventions that states parties are well within their rights to introduce more sophisticated, evidence-informed approaches to addressing drugs than simply relying on criminal prohibition and punishment. For example, with regard to the matter of ensuring treatment for drug dependence, although the conventions "seem to allow very few exemptions for Schedule 1 drugs, methadone is widely available for substitution treatment in many signatory countries."[135] Indeed, methadone has been shown to be cost-effective,[136] the WHO considers methadone and buprenorphine to be among the "essential medicines" that countries should make widely available,[137] and WHO, UNODC, and UNAIDS have urged increased access to substitution therapy for the management of opioid dependence and as a key HIV prevention measure.[138] Unfortunately, not all states parties have taken advantage of the conventions' flexibility to implement such proven health services. Notwithstanding a strong evidence base and extensive international experience demonstrating the benefit of opioid substitution treatment for individual and public health, and numerous policy recommendations from specialized UN agencies, several states, including Russia, have not ensured access to methadone.[139]

States parties are well within their rights to introduce more sophisticated, evidence-informed approaches to addressing drugs than simply relying on criminal prohibition and punishment.

The Russian Federation is a party to all three UN drug conventions, and the three conventions have played a significant role in Russian drug policy.[140] According to the national constitution, international treaties of the Russian Federation are an integral part of its legal system, and rules established by an international treaty supersede national legislation.[141] The prohibitionist approach that is the focus of the UN drug control conventions is reflected in Russia's own domestic law, which even exceeds the conventions' requirements in some cases, including in ways that are damaging to public health, such as the criminal prohibition of methadone.[142] Drug legislation and policy documents cite the UN drug conventions as the source of their guidance in national lawmaking and as an inspiration for Russia's firm prohibitionist approach at the domestic level. For example, the federal *Law on Narcotic Drugs and Psychotropic Substances*, adopted in 1997, opens with an express reference to the UN drug control conventions.[143]

Despite the fact that, as described above, even the UN conventions do not themselves go so far, modern Russia pursues a "zero tolerance" drug policy, under which the government aims at a "drug-free world" primarily through a heavy emphasis on the law enforcement activities supposed to curb both the consumption and trafficking of illegal drugs. Government officials regularly claim that Russia has adopted such an approach in order to meet the UN conventions' drug-eradication goals.[144] For example, in 2001 then-Minister of Interior Affairs Boris Gryslov emphasized that:

> Russia needs to toughen its laws on drugs and totally ban illicit drug use in the Russian Federation. Total prohibition of illicit drug use is not the government's own initiative... but rather a strict adherence to the UN drug conventions... Only criminal law in our opinion can prevent people from committing drug related crimes and force drug dependent individuals to undergo a treatment.[145]

The prohibitionist approach that is the focus of the UN drug control conventions is reflected in Russia's own domestic law, which even exceeds the conventions' requirements in some cases, including in ways that are damaging to public health, such as the criminal prohibition of methadone.

Prominent narcologist and Russian government advisor Edouard Babayan has acknowledged the flexibility inherent in the drug control conventions. He stresses that "neither of the UN conventions requires states parties to follow fully the structural or terminological patterns of the international schedules. This logically follows from the right of states parties to adopt *"stricter measures of control or, on the contrary, exclude some of them."*[146] According to Babayan, this justifies the USSR, and later Russia, adopting stricter measures of control nationally, as compared to the UN drug control conventions.[147] He has noted with pride that Russia is practically the only country that fully fulfils the requirements of the 1971 convention and has adopted even stricter measures than required.[148]

This heavy emphasis on criminal prohibitions on drugs is accompanied by an extensive enforcement apparatus. Since 1991, counter-narcotics operations have become one of the most important and prestigious activities for all Russian law enforcement agencies.[149] Russian politicians and representatives of the Federal Service of the Russian Federation on Control over Drugs Circulation—one of the largest in the world, employing some 40,000 people[150]—often use the rhetoric of the "war on drugs," justifying the reason for the agency's existence with the necessity of fighting "narcoagression against Russia" and the "narcothreat" to the nation.[151] In 2007, the system of antidrug bodies in Russia expanded with the creation of yet another agency—the State Antidrug Committee,

which complements the work of the Federal Service on Control over Drugs Circulation, and is chaired by the same person.[152] There are plans to establish antidrug commissions in the regions of Russia, in order to coordinate district-level antidrug bodies. According to the current director of the Federal Service, Viktor Ivanov: "We have a strong enemy; the fight with it should be conducted as in a war—tough and without mercy."[153]

After the 1998 UNGASS on Drugs, Russia reinforced its commitment to prohibition as its dominant policy approach to drugs by adopting in the following year its own *"Guiding principles and directions of counteraction of illegal narcotics and psychotropic substances and abuse of them for the period until 2008"* (the Guiding Principles).[154] The specific aim of the Guiding Principles, which do not have the force of the law and are non-binding declarations of governmental policy, is to achieve the goals adopted at the UNGASS, namely significant and measurable results in reducing illegal drug consumption by 2008. The preamble of the Guiding Principles repeats verbatim the preamble of the UNGASS Political Declaration. The Guiding Principles reaffirm Russia's intent to "fulfill its obligations in the sphere of drug control in accordance with international treaties and the decisions of the XX UN Special Session of the General Assembly on Drugs."[155] It calls on civil society, political, religious, sports, business, and other leaders to take an active part in "forming a society free from drug abuse." The Guiding Principles stress Russia's solidarity and support for the international community with regard to overcoming the problem of drug use and drug trafficking, and lay down governmental strategy to combat illicit drugs in a number of areas—a strategy that is almost entirely focused on the enforcement of criminal prohibitions as the means to the end of a "drug-free world," and that further declares Russia's objective of ensuring that this approach is adopted or intensified regionally.

According to the current director of the Federal Service, Viktor Ivanov: "We have a strong enemy; the fight with it should be conducted as in a war—tough and without mercy."

The Guiding Principles identify efforts in the area of *demand reduction* that include, among other things, measures that should be taken in order to implement provisions of Article 10 of the 1971 UN convention (prohibiting the advertisement of controlled substances to the general public) and Article 3 of the 1988 convention (which includes the prohibition on publicly inciting or inducing others to commit illegal activity in relation to narcotic drugs). In particular, the Russian government pledges to: "prohibit any forms of propaganda of drug use (interception of dissemination of books, leaflets, brochures, newspapers, etc.) with materials relating to the philosophy and practice of drug use; ... strictly oppose mass media discussions in relation to legalization of the use of drugs and psychotropic substances; create and strengthen specialized subdivisions operating within the framework of law enforcement agencies."[156]

In relation to *supply reduction*, the Guiding Principles state Russia's goal of strengthening regional cooperation by the CIS countries in enforcing prohibition, especially in the area of amending national laws in relation to illicit drugs, consolidating the efforts of the international community in the struggle against narcotics trafficking, and facilitating multilateral intergovernmental anti-narcotics agreements with the CIS countries.[157]

Finally, the *international cooperation section* of the Guiding Principles further makes clear Russia's intent to project its prohibitionist approach regionally, including its opposition to evidence-based treatment options for those with opioid dependence. The Guiding Principles explicitly state Russia's policy to engage in the following efforts:

- "[c]arry out activities with regard to consolidation of the international community's efforts in the struggle against illegal trafficking of narcotics and abuse thereof under the auspices of the United Nations";
- "oppose legalization of the non-medical consumption of narcotics and psychotropic substances and the decriminalization of offenses connected with it";
- "counteract attempts to develop and apply methadone programs and opium and heroin treatment programs"; and
- "endeavors shall be made to bring legislation of participant countries of the CIS into conformity with... the CIS model *Law on the Prevention of Illegal Traffic in Drugs, Psychotropic Substances and Precursors.*"[158]

The Russian "war on drugs" approach does not end within the extensive Russian territory. In order to achieve drug demand reduction goals stipulated by the UNGASS 1998, Russia adopts a strategy that totally condemns any attempts to develop and apply methadone programs, to initiate media discussion on the subject of drugs (including methadone and other harm reduction measures), and to legalize any kind of drugs, not only in Russia, but in the entire region.

As seen from the Guiding Principles, the Russian "war on drugs" approach does not end within the extensive Russian territory. In order to achieve drug demand reduction goals stipulated by the UNGASS 1998, Russia adopts a strategy that totally condemns any attempts to develop and apply methadone programs, to initiate media discussion on the subject of drugs (including methadone and other harm reduction measures), and to legalize any kind of drugs, not only in Russia, but in the entire region.

Former President and now Prime Minister Vladimir Putin acknowledges that Russia has extremely strict criminal responsibility for offenses related to drugs, with criminal sanctions of up to 20 years' imprisonment possible for trafficking.[159] According to Putin,

"the question is not in making the law stricter, but to ensure the unavoidability of punishment, as for any other crime. And this is the road we are going to take further on."[160] It is, therefore, not surprising that some modest moves toward tempering the harshness of Russian drug law have subsequently been revised.

In 2003, the federal Duma took an important step toward revisiting federal criminal law in relation to drug offenses by significantly increasing the minimal quantity of drugs that could lead to criminal liability for the offense of possession. Legislative amendments introduced the notion of an "average dose" of an illegal substance, and defined a "large amount" of drugs as 10 or more average doses and an "extra large amount" as 50 or more average doses.[161] Purchasing, possessing, manufacturing, importing, and exporting illegal drugs in a quantity less than 10 average doses would lead to administrative, rather than criminal, liability.[162] Compulsory treatment of drug dependent offenders in prisons was abolished, alternatives to imprisonment were introduced, and manufacturing narcotic drugs for personal use was differentiated from manufacturing with the intent to sell.[163,164]

Yet that move has since been partly repealed: the concept of an "average dose" has been revoked and the definitions of "large" and "extra large" amounts of drugs have been revisited once again.[165,166] The deputy director of the Federal Service on Control over Drugs Circulation called the Duma's 2003 amendments "a mistake, which now has been learned and corrected."[167] According to him, one of the strategic directions of Russia's drug policy is full implementation of provisions of the UN drug control conventions, in particular strict compliance with the drug schedules.[168] As of this writing, the Federal Service of the Russian Federation on Control over Drugs Circulation proposes to repeal the remaining amendments from 2003, increase criminal sanctions for the sale of drugs in small amounts, and re-establish compulsory drug dependence treatment.[169] The agency's proposals include adoption of "extraordinary strict measures of control in relation to drugs for medical and scientific purposes," and the expansion of forced drug testing, particularly in schools and other educational institutions.[170]

Regional cooperation in the area of drug control

Having reviewed the basic orientation of the three UN drug control conventions, and the role they play in the Russian Federation's legislative and rhetorical approach to drugs, this section provides an overview of how both the UN norms and Russia's approach have influenced other countries within the region and within Russia's historical sphere of influence. The focus is primarily on Russia's efforts via the processes of the Commonwealth of Independent States, including developing model legislation and promoting its adoption by member states. More briefly, some reference is made to other regional bodies for addressing drug control, which also are overwhelmingly oriented toward the use of law enforcement mechanisms to address drugs. Just as Russia maintains an extensive appa-

ratus for drug law enforcement domestically, at the regional level there is also a proliferation of bodies, agreements, recommendations, and declarations aimed at reifying prohibition as the dominant response to drugs.

Commonwealth of Independent States

Founded in 1991 and headquartered in Minsk, Belarus, the Commonwealth of Independent States is an international organization consisting of 12 former republics of the Soviet Union,[171] with the purpose of promoting integration and cooperation on economic, defense, and foreign policy matters.[172] Created in 1992, the Inter-Parliamentary Assembly (IPA) of the CIS is an advisory body for the preparation of "draft legislative documents of mutual interest," based in St. Petersburg, Russia.[173]

Just as Russia maintains an extensive apparatus for drug law enforcement domestically, at the regional level there is also a proliferation of bodies, agreements, recommendations, and declarations aimed at reifying prohibition as the dominant response to drugs.

One of the main goals of the CIS, and one of the major reasons for the existence of the IPA, is the "harmonization and unification" of legislation of the CIS Member States. This work is implemented through the adoption of model legislative acts and recommendations. Since its inception, the IPA has adopted over 200 model legislative acts, including model Civil, Criminal, Criminal Procedure, and Tax Codes.[174] In 1996 and again in 2006, at the initiative of its Permanent Commission on Defense and Security Issues, the IPA adopted two model laws on drugs[175] and recommended that parliaments of CIS Member States use these in preparing their own national legislation.[176]

Apart from adopting the two model laws on drugs, the "fight against narcoagression" and the "narcothreat" that faces the region in the 21st century represent a major focus of the lawmaking efforts of the CIS, which has convened several conferences, consultations and roundtables on the subject of the fight against drugs. In 2002, the Heads of State of the CIS countries adopted the "Concept for cooperation between the Member States of the CIS in activities to combat illicit trafficking in narcotic drugs, psychotropic substances and precursors."[177] Resulting from this were two cooperation programs between CIS Member States for activities to combat illicit trafficking in narcotic drugs, psychotropic substances, and their precursors, covering the periods of 2002-2004 and 2005-2007 respectively.[178] Complementing the first of these cooperation programs, in order to intensify further the legislative activity in this area, in October 2004 the IPA established a Joint Commission on Harmonization of Legislation in the Sphere of Combating Terrorism, Crime and Drug Business.[179] As part of the latter cooperation program, Russia's

Key Elements of the CIS Model Law on Drugs

1996 MODEL LAW "ON THE PREVENTION OF ILLEGAL TRAFFIC IN DRUGS, PSYCHOTROPIC SUBSTANCES AND PRECURSORS"

Drug use in a group or in public spaces is prohibited. Illegal purchase, possession, import, and export of narcotic and psychotropic substances in small quantities for personal use leads to administrative penalty for a first offense. A second or subsequent offense within the same year leads to criminal prosecution. Private and public bodies, and individuals in their personal capacity, have a legal obligation to report all instances of use, possession, cultivation, trafficking and other activities with illegal drugs.

Anyone suspected of using or being under the influence of illicit drugs may be subjected by police to involuntary drug testing. Witness statements alone suffice as evidence in a prosecution to "prove" drug use.

Compulsory drug dependence treatment may be imposed. The law provides for administrative liability for avoiding drug testing and treatment or not following a physician's orders. Police may enforce testing or treatment, including through involuntary detention, in the event that a person seeks to evade it. There is criminal liability for escaping a medical institution following involuntary detention.

A court decision ordering drug dependence treatment is a basis for dismissal from work and termination of enrolment in an educational institution. The law provides for mandatory registration of people who use drugs. Those registered may be deemed temporarily unfit to perform certain functions (although these are not specified in the model law).

There is no mention of the rights of people who use drugs, even those who are drug-dependent, nor of any possibility of appeal of police or court decisions to order a person to undergo compulsory drug testing and treatment.

2006 MODEL LAW "ON NARCOTIC AND PSYCHOTROPIC SUBSTANCES AND PRECURSORS"

Drug use *per se* is prohibited and punished with a fine or administrative detention. Purchase or possession of drugs for personal use, even in small amounts, and avoiding or refusing to undergo drug testing, leads to administrative arrest.

For purposes of detecting those who use drugs, the state organizes preventive drug testing, including during annual check-ups of students at all levels of education. If there are reasonable grounds to believe that a person uses illicit drugs or psychotropic substances, or is under the influence of narcotic drugs, s/he is ordered to undergo drug testing by a court, prosecutor, or investigating officer. Sanctions may be imposed for avoiding drug testing or treatment, or for not following doctors' orders. Escape from or en route to a specialized medical facility is punishable by imprisonment and fine.

The model law provides for registration of people with drug dependence; those registered may temporarily be deemed unfit to perform certain functions (although these are not specified). A court decision ordering a person to undergo addiction treatment is a basis for dismissal from work or termination of enrolment in an educational institution.

There is no mention of the rights of people who use drugs, even those who are drug-dependent, nor of any possibility of appeal of police or court decisions to order a person to undergo compulsory drug testing and treatment.

* * * * *

The 1996 model law focuses on criminal and administrative sanctions for illegal activities related to narcotic drugs (which are placed in national criminal and administrative codes) and the treatment of drug dependence; it is primarily a set of provisions aimed at prohibitions and their enforcement. The 2006 model law similarly has a strong prohibitionist orientation, yet is also a more comprehensive document. It regulates in detail the mandate of the drug control agency and regulates the legal use and distribution of narcotic drugs. The 2006 CIS model law refers to the UN drug control conventions in defining precursors, adopting international quotas of narcotic substances, and in licensing criteria.

Patients are handcuffed to their beds at a rehabilitation program in Yekaterinburg, Russia. Up to 50 people at a time are crammed into a room and fed a diet of only bread and water to ensure they take the treatment seriously. Brendan Hoffman

Federal Service on Control over Drugs Circulation participated in drafting the model law on drugs subsequently adopted by the CIS' IPA in 2006.

There is evident overlap between Russian drug law and the legislative drafting work of the CIS. This is not surprising, given that the Russian federal drug control agency took an active part in drafting at least the 2006 CIS model law, consistent with its declared objective of strengthening, on a regional level, the enforcement of criminal prohibitions on drugs.[180] There are evident similarities between Russia's 1997 "Law on narcotic drugs and psychotropic substances" and the 2006 CIS model law. Consider the following examples:

- The 1997 Russian law on drugs prohibits drug use *per se*.[181] (The drug law does not define the penalty for breaching the prohibition; rather, this is left to the *criminal or administrative codes*.[182]) The 2006 CIS model law similarly recommends prohibiting drug use.
- The 1997 Russian law prohibits treatment using methadone and buprenorphine: "the use of narcotic drugs and psychotropic substances included in List II for the treatment of drug dependence shall be prohibited."[183] The 2006 CIS model law incorporates this provision word for word[184]—although as discussed below, fortunately this approach has not been reflected in the practice of various CIS member states, a number of which have moved ahead with implementing opioid substitution treatment.

- Similarly, the Russian 1997 law and the CIS 2006 model law are identical in their prohibition of so-called propaganda: "Propaganda of narcotic drugs and psychotropic substances (e.g., individuals' and organizations' activities disseminating information about ways, methods of development, manufacture and use, places to find drugs, and also printing and dissemination of books, and other printed and media information, dissemination of information on TV and other means of communication, and other activities aimed at it), is prohibited. Propaganda of advantages of use of some drugs over another, and propaganda of drug use for medical purposes, which affects a person's will or having a negative impact on one's psychological or physical health, is prohibited."[185]

The UN drug control conventions and the 1998 UNGASS on Drugs serve as the constant backdrop to the work of the CIS in this area, with the CIS serving as an echo chamber in which the conventions are constantly invoked, affirmed and urged upon member states.

It is difficult to gauge the degree to which the CIS model laws themselves, as distinct instruments, have influenced the development of national legislation or policy in CIS member states, including the Central Asian countries. A number of states have moved to implement opioid substitution treatment programs despite the explicit opposition to such measures expressed in the 2006 CIS model law (which itself is drawn verbatim from Russia's 1997 law). However, in other respects, legislation in member states is broadly consistent with the other elements reflected in the CIS model laws, such as provisions for compulsory drug testing and treatment, drug user registration, and legislatively mandating restrictions on those registered as drug users. Timing may be one of the reasons explaining the seemingly limited incorporation of at least the 1996 CIS model law's provisions. The Central Asian countries adopted their national drug laws in 1998 and 1999, by which time Russia had adopted its own, more fully developed drug law in 1997. Given the evident similarities between the Russian law and the legislation of the Central Asian republics, it seems that Russia's law has been more of a direct influence on countries in the region than the earlier CIS model law. Later, by the time the CIS IPA adopted its second model law on drugs in 2006, each country's own legislation was already in place—it remains to be seen whether this second model law will gain much traction with the region's national governments, but to date there is little evidence of this.

What is clear is that the UN drug control conventions and the 1998 UNGASS on Drugs serve as the constant backdrop to the work of the CIS in this area, with the CIS serving as an echo chamber in which the conventions are constantly invoked, affirmed

and urged upon member states. At a 2003 international CIS conference in St. Petersburg, the participants adopted recommendations "On implementation of the UN Drug Control Conventions in the National Legislation of the CIS countries," calling on member states to speed up the harmonization of legislation in fighting against the "narcothreat."[186] The resolution's preamble notes that the recommendations are "guided by the provisions and principles of the UN drug control conventions and the Political Declaration and decisions adopted at the XX Special Session of the UN General Assembly in 1998." It continues by "underlining that all member states of the CIS ratified these international drug control conventions" and "remembering that at the XX Special Session of the General Assembly of the UN, dedicated to the joint fight against the global drug problem, the States recognized that drug demand reduction is an important element of comprehensive approach to solving the drug problem."[187]

In 2004, the Council of the Heads of States of the CIS countries adopted a "Program of Cooperation of the CIS Member States in the Fight against Illegal Trafficking in Drugs, Psychotropic Substances and Precursors for 2005-2007."[188] Among the main goals of the program are: improvement and harmonization of national legislation, and development and strengthening of international legal basis for the cooperation in the area of drug control. The program activities include adoption of legislation aimed at: (a) toughening criminal law sanctions for trafficking, importation, and transit of illegal drugs; (b) strengthening criminal sanctions for the sale of drugs to minors; (c) introducing liability for drug use; (d) prohibiting propaganda of drugs and drug use; and (e) preventing drug dependence, identifying, treating, and rehabilitating people with drug dependence, and preventing HIV/AIDS, and hepatitis A, B, and C among drug users.[189] Accordingly, the Russian Federation's Federal Service on Control over Drugs Circulation took a lead in drafting for the CIS Inter-Parliamentary Assembly the model law on drugs eventually adopted in 2006.

In November 2005, the CIS held yet another conference in St. Petersburg, at which member countries adopted a "Declaration of the International Conference on Problems of International Cooperation in the Sphere of the Fight against Drug Dependence and Illegal Drug Trafficking" in the CIS countries. The declaration urged states to:

- regularly conduct antidrug and anti-trafficking activities;
- organize international projects on drug control and joint actions to reduce drug demand, prevent drug dependence, and enhance treatment and rehabilitation;
- further develop and strengthen the treaty basis for international cooperation on the fight against drugs; and
- take action to harmonize national legislation in the sphere of drug abuse and trafficking.[190]

The declaration recognizes the leading role of the UN in organizing the fight against illegal drugs and drug use, and supports the existing international treaties, and the UN

General Assembly's 1998 Political Declaration and related decisions. The declaration underlines the role of the parliamentarians in forming a "barrier" to illegal drug trafficking and drug use and stresses the importance of the CIS model laws and the IPA's 2003 recommendations on the unification of drug legislation.

Most recently, the IPA adopted in November 2006 a further resolution aimed at harmonizing legislation and implementing intergovernmental plans for fighting against drugs and crime, through the "Recommendations on unification and harmonization of legislation in the area of combating trafficking of narcotic drugs, psychotropic substances and precursors."[191] The resolution reaffirmed the CIS' commitment to creating and improving international standards in combating current threats and challenges to security on the territory of the CIS, including drugs. This resolution endorsed the 2006 CIS model law on drugs and the IPA's earlier 2003 recommendations on the unification and harmonization of legislation on drugs. These new 2006 recommendations again reference the UN drug conventions, as well as provisions of the 1996 CIS model law on drugs. In these 2006 recommendations, CIS member countries state that, despite the fact that all national laws are based on the same international treaties, there is an absence of unified terminology in the area of combating illegal drug trafficking. Furthermore, concern is expressed about differences in how member states address the scheduling of controlled drugs and terms of amending such schedules, as well as variation in provisions for criminal prosecution and liability for large and extra-large amounts of drugs. The unification of the above provisions is the current goal of the IPA.

In the political rhetoric of the CIS countries, "narcoagression" is characterized as a threat to national security.[192] The Russian Federation's representatives are joined by the CIS IPA members in their repeated calls for the harmonization and unification of national legislation in the area of drug control.[193] In his speech to the IPA, the chair of the Committee on Defense and Security of the Federation Council of the Federal Assembly of Russia (the upper house of the parliament) has underlined that it is not only the IPA, but also the parliament of the Russian Federation that undertakes efforts aimed at the harmonization and unification of the legislation in the area of counteraction to narcoagression in the CIS countries and internationally.[194] According to the chair of the Federation Council of the Federal Assembly, S. M. Mironov, joint efforts in combating narcoagression in the CIS and the entire international community are necessary, and are priorities of the IPA since its inception.

Other regional cooperation on drug law enforcement

Beyond the larger forum of the CIS, Russia and most of the Central Asian countries are also engaged in at least two other regional bodies that devote considerable attention to reinforcing the dominance of a criminal prohibition approach to addressing drugs.

A prisoner with tuberculosis in Tomsk, Russia waits to receive medication at a local prison hospital. HIV and TB are common infections among drug users in Russia's prisons. Gary Calton/Panos

The **Collective Security Treaty Organization** (CSTO) is a political and military organization of seven former Soviet Union countries, established in 2002 on the basis of the 1992 CIS Collective Security Treaty, with counteracting drug trafficking as one of its goals.[195] In 2003, the CSTO adopted a decision "On strengthening measures to combat drug dependence and drug trafficking as financial basis of transnational organized crime."[196] According to a Kazakh parliamentarian, recommendations on unifying and harmonizing the legislation of CSTO member states in combating international terrorism and drug trafficking have been used to toughen the drug law of Kazakhstan.[197] More recently, in March 2008, there was a meeting of the coordination council of the heads of the national drug control agencies (within the framework of the CSTO)[198], with the main goal of pursuing unification of legislation in the area of drug control.[199] The coordination council was created in 2004 to fight "narco-expansion" in the region, and has since coordinated a number of high-profile border control anti-trafficking operations in the region. The coordination council is currently chaired by the former Director of the Russian Federal Service on Control over Drugs Circulation.[200]

The **Shanghai Cooperation Organization** (SCO) is an intergovernmental international organization created in 2001 in Shanghai, China.[201] According to the president of Kazakhstan, Nursultan Nazarbaev, one of the SCO's priorities is the fight against drugs.[202] In 2004, the six member states of the SCO signed an agreement to cooperate in combat-

Table 4. Drug statutes in Russia and Central Asia: key elements

	Prohibition of nonmedical use of drugs[204]	Compulsory treatment of drug dependence[205]	Compulsory drug testing if suspected of drug use	Registration of drug users	Prohibition of "propaganda"[206]
Russia	■	■	■	■	■
Kazakhstan		■	■	■	■
Kyrgyzstan		■	■	■	■
Tajikistan	■	■	■	■	■
Uzbekistan		■	■	■	■

ing illegal drug trafficking.[203] The preamble of the agreement recognizes the importance of the UN drug control conventions and the Political Declaration and decisions adopted in 1998 at the XX Special Session of the UN General Assembly on Drugs, and other recommendations of the United Nations. Member states agreed to cooperate and coordinate their efforts in the struggle against drugs, and to present a unified position at international fora on drugs.[207] Rooted firmly in a prohibitionist framework, the agreement acknowledges that the member states, according to their national legislation, may criminalize nonmedical drug use in order to prevent drug demand and drug dependence.[208] During their August 2007 meeting in Bishkek, Kyrgyzstan, the SCO member states reaffirmed their previous plans and decided to actively implement the 2004 agreement.[209] Finally, beyond these regional organizations, the UN drug control treaties provide a touchstone for drug law enforcement efforts via several bilateral agreements between drug control agencies of the CIS countries.

As illustrated by the overview above, the fight against "narcoaggression" is one of the main priorities of several intergovernmental organizations within Eurasia. Every agreement and recommendation adopted by those bodies uses the language of a "war on drugs" and cites the UN drug control conventions as well as the declaration and decisions of the 1998 UNGASS on Drugs. Unfortunately, with the proposed activities mainly focused on law enforcement, there is little mention by such regional bodies of the importance of protecting human rights, efforts to prevent the spread of HIV, or the development of effective drug dependence treatment. The absence of these considerations is unhelpful, given the ever-growing body of evidence as to the negative human rights and public health consequences of a strict and lopsided emphasis on prohibition, prosecution, and punishment

as the primary means of addressing drugs and related harms. It is worth noting that the UN General Assembly has affirmed the importance of ensuring that drug control must be carried out in conformity with States' human rights obligations,[210] and the UN Commission on Narcotic Drugs itself has recognized their importance.[211]

National drug law and policy in Central Asia

For the purposes of this paper, we review the situation in the four Central Asian countries that are CIS members: Kazakhstan, Kyrgyzstan, Uzbekistan, and Tajikistan. The UN drug control conventions are cited directly in the drug statutes of three: Kazakhstan,[212] Tajikistan,[213] and Kyrgyzstan.[214] Typically, national legislation in each country either proclaims the priority of international treaties ratified by the country over national laws[215] or proclaims the treaties as part of national legislation.[216] All four countries adopted their national drug laws in the period of 1998-1999.[217] In some respects, they reflect elements found in the 1996 CIS model "Law on the prevention of illegal traffic in drugs, psychotropic substances and precursors." They resemble closely the 1997 Russian "Law on narcotic drugs and psychotropic substances."[218]

Unfortunately, with the proposed activities mainly focused on law enforcement, there is little mention by such regional bodies of the importance of protecting human rights, efforts to prevent the spread of HIV, or the development of effective drug dependence treatment.

The Kazakh, Kyrgyz, Uzbek, Tajik, and Russian laws on drugs vary in length but follow the same basic structure. Some articles of the Central Asian countries' national statutes on drugs are identical in wording or in essence to the 1997 Russian law on narcotics.[219] Common characteristics between Russian and Central Asian statutes specifically on drugs are shown on the table below. (Note that Table 4 summarizes only countries' specific statutes on narcotic drugs. In each country on the table, these statutes are supplemented by criminal and administrative codes and various resolutions that may introduce additional regulatory elements or interpret drug laws.[220])

Yet despite their support on paper for the CIS project of harmonizing and unifying legislation in the field of drug control, and very similar wording of their drug laws, in reality the drug policies of the Central Asian countries are somewhat different. All four Central Asian countries that are member states of the CIS implement harm reduction strategies to varying degrees. For example, as of this writing, Kyrgyzstan and Uzbekistan had implemented opioid substitution treatment (OST) on a limited level, but proclaimed their commitment to its expansion; as of October 2008, Tajikistan was expecting to establish

two pilot sites for providing OST in the near future;[221] and Kazakhstan had yet to implement OST. In 2008, Kyrgyzstan became the first country in the region to introduce OST in prisons. All four countries have needle exchange programs; in 2002, Kyrgyzstan became the first country in the region to introduce such programs in prisons.[222] (In contrast, Russia continues to prohibit criminally the use of methadone or buprenorphine for OST, and, while needle exchange programs are operating, none yet exist in any Russian prison setting.)

Furthermore, in fora other than the CIS, politicians from various Central Asian countries show some openness to harm reduction interventions, and acknowledgement of the negative consequences of an approach to drug use that relies exclusively on enforcing criminal prohibitions and penalties.

In 2007, addressing the United Nations in a letter, the government of **Uzbekistan,** while underlining its adherence to the international drug control conventions, also recognized that primary prevention of drug dependence is important, and that access to effective, humane drug dependence treatment and rehabilitation is essential.[223]

In **Tajikistan**, the national coordination committee responding to HIV/AIDS, tuberculosis and malaria established a working group to study prospects for introducing OST in the country and lead the establishment of pilot programs.[224] Following amendments to the criminal code in 2004, which significantly increased the minimum quantities of drugs required to trigger criminal liability for possession, Tajikistan has one of the most liberal drug amount tables in the former Soviet Union.[225]

Kyrgyzstan, the first country to introduce comprehensive interventions to reduce harms from drug use,[226] and which recently increased the minimal amounts of narcotic drugs prohibited for circulation,[227] continues to implement drug policy that does not follow either Russia's strict model or the official prescriptions of the CIS. According to Timur Isakov, advisor to the director of the drug control agency of Kyrgyzstan:

> The IPA of the CIS developed a model law on counteraction to drugs. Very good, excellent, great. But when our parliamentarians took part in this work, they did take into account the way Kyrgyzstan is moving, what direction it has chosen in this sphere. This is important...We are trying to move forward and develop our drug policy taking into account our local situation...China (with 2 billion people), Russia (with 150 million), U.S. (with 300 million)—all of them have very tough drug policies...If we copy their style, create big structures, apparatus, methods, we will not have enough financial resources and people. Additionally, who will benefit? After having worked in this area a long time, Kyrgyz experts came to the conclusion that we need to take into account the experience of countries which are similar to Kyrgyzstan...Russia refused to implement programs that reduce the harms of drug use (needle exchange, methadone

A prison officer in Dushanbe, Tajikistan checks a cell in the special detention center run by Tajikistan's Drug Control Agency. Alessandro Scotti/Panos

> programs, etc.), prohibited their existence...On the other hand Kyrgyzstan does not have a right to experiment...as I joke, we do not have enough population for those experiments...We must take the paths that are proven to work.[228]

Indeed, government officials at the highest level in Kyrgyzstan have challenged the strict prohibitionist approach adopted by Russia and reflected in the CIS model laws. At a June 2005 conference, "Kyrgyzstan: A Future without Drugs," Kyrgyz President Kurmanbek Bakiyev declared:

> It is time to stop incarcerating people who use drugs... From our point of view, the system where people who use drugs are criminally charged with possession of small amounts of drugs is not acceptable... It diverts state efforts and funding from activities directed against trafficking, creates an illusion of work...We need to study carefully and reform decisively legal provisions relating to illegal drugs and prevention of drug use.[229]

In sharp contrast, unlike these three sister countries in Central Asia, **Kazakhstan** persists with "war on drugs" rhetoric and policies. In a long-term governmental policy "Kazakhstan 2030," President Nursultan Nazarbaev declared:

> It is necessary to toughen punishment for drug trafficking and drug dealing... Drugs is a special and deadly sphere, and it is a question to what extent the principles of humanism are applicable here. On one side of the scale there is the life of the person who imports and deals drugs, on the other, the lives of people who use drugs that are destroyed with his "help."[230]

More recently, Kazakhstan's parliament has enacted legislation toughening sanctions for drug-related offenses, introducing life imprisonment for selling drugs in educational institutions and to minors, for dealing in extra-large quantities of drugs, and trafficking by organized groups.[231] The law also toughens the liability of entertainment venues for drug offenses taking place on their premises. The government is currently considering introducing forced drug testing for students.[232]

As the review above indicates, some governments of the Central Asian countries have pursued, at least to some degree, more independent drug policies with more attention to implementing evidence-based harm reduction interventions. However, despite some positive changes, introduction of evidence-proven interventions based on principles of human rights and protection of public health is slow in the Central Asian countries. In many respects, national drug laws remain imitations of the outdated and punitive 1997 Russian law, with no provisions for harm reduction measures that protect the health of both individuals who use drugs and that of the public more broadly, including through preventing the spread of HIV. The past decade has seen a concerted effort by Russia to push a strict prohibitionist approach to drugs at a regional level, including through the

structures of the CIS and other regional bodies, even as evidence has mounted that such an approach is counterproductive and damaging to public health.

Conclusion and recommendations

> "Whether or not they are a cause or a convenient excuse, UN drug conventions are used by national governments to justify highly punitive legal measures and failure to implement services for people who use drugs."
>
> — Oleg Feodorov, Deputy Minister of Internal Affairs, Kazakhstan[233]

Russia leads the war on drugs in the region, advancing its strict interpretation of the UN drug control conventions and frequently citing the UNGASS 1998 decisions as its inspiration. More troubling is that Russian influence is evident in the legislation of at least some of the CIS countries.

As is apparent from the preceding review, the UNGASS objective of achieving a "drug-free world" through prohibition has played a central normative role in the development of drug policy in Russia and the CIS. Russia leads the war on drugs in the region, advancing its strict interpretation of the UN drug control conventions and frequently citing the UNGASS 1998 decisions as its inspiration. More troubling is that Russian influence is evident in the legislation of at least some of the CIS countries. This influence is reinforced through the regional mechanisms of the CIS and other regional intergovernmental organizations. Fortunately, the repressive 1996 and 2006 CIS model laws, which have gone further in their harshness than Russia's national law, have not been transplanted directly into national legislation anywhere, including in Russia. The actual Russian legislation, however, does have an impact on legislation and policies in the CIS countries. For various reasons (lack of national expertise, common history and mentality, or geopolitical influence), the Russian example is still important for the neighboring countries. The dominance of law enforcement and drug control policy over public health and medical ethics is especially evident in Russia and Kazakhstan. Other countries are more careful in their policies and are more inclined to follow evidence-informed interventions in relation to drug use, which are tailored to the specific situation in their countries.

An approach of harsh drug laws and policies, accompanied by an extensive enforcement machinery—both at the national level in countries such as Russia in particular, and at the regional level through a proliferation of intergovernmental agreements and bodies—has failed to stem the surge in drug use in Russia and the Central Asian countries.[234] This approach has also led to various violations of human rights of people who use drugs

and exacerbated the HIV epidemic in some of the CIS countries. Given the human, economic and social costs at stake, it is time to rethink the basic approach. In reforming their laws and policies, governments of the region need to take into account the impact of their policies on public health and human rights. They need to recognize the benefits to be gained from respecting, protecting, and fulfilling the human rights of people who use drugs and from implementing evidence-based interventions, including diverse methods of drug dependence treatment such as OST, and harm reduction programs such as needle exchange.

An approach of harsh drug laws and policies, accompanied by an extensive enforcement machinery … has failed to stem the surge in drug use in Russia and the Central Asian countries. This approach has also led to various violations of human rights of people who use drugs and exacerbated the HIV epidemic in some of the CIS countries.

The Russian government should enact the following recommendations:

- Reconsider its narrow interpretation of the UN drug control conventions and use the flexibility in the conventions allowing public health interventions to address drug dependence instead of solely focusing on criminal punishment.
- Introduce reforms to eliminate or mitigate the harsh administrative and criminal penalties imposed for nonviolent drug offenses and drug use.
- Integrate evidence-based drug treatment policies into the drug treatment system.
- Immediately lift the ban on the medical use of methadone and buprenorphine in the treatment of drug dependence and introduce maintenance therapy programs.
- Repeal the use of registries of people who use drugs and the associated limitations of the rights of those who are registered.

Member states gathered in regional intergovernmental organizations such as the CIS and its Inter-Parliamentary Assembly should focus greater regional cooperation on the objectives of introducing evidence-based harm reduction interventions and of respecting, protecting and fulfilling the human rights of people who use drugs. It is not clear that the CIS IPA's two model laws on drugs have had more than perhaps an indirect influence on the domestic legislation of member states in Central Asia. However, if the development and promotion of model laws is to remain a central activity of the IPA, it could take up the challenge of drafting model legislation on drugs that reflects human rights principles and supports the effective implementation of harm reduction services.[235]

Member states of the CIS should:

- Continue developing national drug policy with recognition of the specific situations in their countries, and flexibility offered by the UN drug control conventions.
- Take into account lessons learned in human rights protection and effective public health interventions in relation to people who use drugs when developing regional policy.
- Scale up opioid substitution treatment where it exists and immediately introduce it where it does not.
- Evaluate the effectiveness of compulsory drug dependence treatment, with a view to abolishing it as likely ineffective.
- Repeal the use of registries of people who use drugs and the associated limitations of the rights of those who are registered.

Notes

101 E.g., a UN survey of government officials in seven Asian countries noted that one of the reasons given for lack of substitution therapy was the belief that methadone was prohibited by the spirit or the letter of the conventions: UNAIDS/UNODCCP, *Drug Use and HIV Vulnerability* (Geneva/Vienna: UNAIDS/UNDCCP, 2000).

102 See, e.g., J. Csete & R. Pearshouse, *Dependent on Rights: Assessing Treatment of Drug Dependence from a Human Rights Perspective* (Toronto: Canadian HIV/AIDS Legal Network, 2007), pp. 24-25.

103 E.g., Human Rights Watch, *Rehabilitation Required: Russia's Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment*, November 2007, Vol.19, No 7(D).

104 Ibid.

105 E.g., Human Rights Watch, *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation*, April 2004, Vol. 16, No.5 (D); Human Rights Watch, *Fanning the Flames: How Human Rights Abuses are Fuelling the AIDS Epidemic in Kazakhstan,* June 2003, Vol. 15, No. 4 (D).

106 UNDCP (Legal Affairs Section), Flexibility of treaty provisions as regards harm reduction approaches, Decision 74/10, UN Doc. E/INCB/2002/W.13/SS.5 (30 September 2002), online at: www.tni.org/drugsreform-docs/un300902.pdf.

107 D. Barrett et al., *Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy* (London: The Beckley Foundation Drug Policy Program, March 2008), p. 3.

108 Commonwealth of Independent States, *Complementary drug-related data and expertise to support the global assessment by Member States of the implementation of the declarations and measures adopted by the General Assembly in its twentieth special session: Report by the Commonwealth of Independent States (CIS)*, UN Commission on Narcotic Drugs, 51st Session (2008), UN Doc. E/CN.7/2008/1, online: www.unodc.org/documents/commissions/CND-Session51/CND-UNGASS-CRPs/ECN72008CRP06.pdf [hereinafter "CIS Report to CND (2008)"].

109 United Nations Office on Drugs and Crime, Regional Office for Central Asia, *Compendium of Drug-Related Statistics 1997-2008*, June 2008, p. 29.

110 V. Ivanov, Chief of the Federal Service on Control over Drugs Circulation, "On the drug situation in the Russian Federation: New challenges and threats," Presentation to meeting of chief narcologists and chief pediatric narcologists of the public health system of the regions of the Russian Federation, 18 September 2008 (in Russian), online: www.narkotiki.ru/gnk_6614.html.

111 UNODC, *Compendium 1997-2008*, ibid.

112 B. Mathers et al., "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review," *Lancet* 2008; 327 (24 September), doi:10.1016/S0140-6736(08)61311-2, online in full via website of Reference Group to the United Nations on Injecting Drug Use and HIV, www.idurefgroup.unsw.edu.au/IDURGWeb.nsf/page/publications.

113 V. Ivanov, Chief of the Federal Service on Control over Drugs Circulation, "On the drug situation in the Russian Federation: New challenges and threats"; and UNODC, *Compendium 1997-2008*, op. cit.

114 Mathers et al., op. cit.

115 C. Cook & N. Kanaef, *Global State of Harm Reduction 2008: Mapping the Response to Drug-related HIV and Hepatitis C Epidemics* (London: International Harm Reduction Association, 2008), p. 37; UNODC, *Compendium 1997-2008*, op. cit., p. 32.

116 UNODC, *Compendium 1997-2008*, op. cit., p. 32.

117 UNODC, *Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan: Regional study on drug use and HIV/AIDS,* Regional Summary, 2007, p. 16.

118 UNAIDS, *Eastern Europe and Central Asia: 2007 AIDS epidemic update: regional summary* (Geneva: UNAIDS, 2008), p. 3.

119 UNAIDS/WHO, *Report on the Global HIV/AIDS epidemic* (Geneva, June 1998), online: http://data.unaids.org/pub/Report/1998/19981125_global_epidemic_report_en.pdf.

120 UNAIDS, *2008 Report on the global AIDS epidemic* (Geneva, 2008), Annex 1.

121 UNAIDS, *2008 Report on the global AIDS epidemic*, op. cit., p. 52.

122 UNAIDS, *Eastern Europe and Central Asia*, op. cit., pp. 3, 7.

123 UNODC, *Compendium 1997-2008*, op. cit.

124 B. Mathers et al, "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review". (Data for Central Asian republics is from 2005, for Russia from 2003.)

125 UNAIDS, *Eastern Europe and Central Asia: 2007 AIDS epidemic update: regional summary* (2007).

126 Ibid.

127 *Single Convention on Narcotic Drugs* (1961), 520 UNTS 331, as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs.

128 *Convention on Psychotropic Substances* (1971), 1019 UNTS 175.

129 *Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988), UN Doc. E/CONF.82/15.

130 1988 Convention, Article 3. However, as has been noted elsewhere, a careful reading of this article indicates that the obligation is simply to criminalize possession for personal consumption that is "contrary to the provisions" of the two earlier Conventions. Thus, the flexibility found in the two earlier conventions is preserved—including those provisions that allow States Parties to refrain from criminalizing people who possess drugs if such an approach is in pursuit of "medical or scientific purposes" or if it forms part of practicable measures to provide care, treatment, or support to people who use drugs, for which the Conventions make explicit provision: *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS—Module 1: Criminal Law Issues* (Toronto: Canadian HIV/AIDS Legal Network, 2006), pp. 12-13, online via www.aidslaw.ca/modellaw.

131 D. Bewley-Taylor, "Challenging the UN drug control conventions: problems and possibilities," *International Journal of Drug Policy* 2003; 14: 171-179; D. Wolfe & K. Malinowska-Sempruch, *Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches* (New York: Open Society Institute, 2004).

132 1961 Convention, Article 33; 1971 Convention, Article 20.

133 1988 Convention, Article 3(4)(d).

134 *Declaration on the Guiding Principles of Drug Demand Reduction,* op. cit.

135 Wolfe & Malinowska-Sempruch, *Illicit Drug Policies and the Global HIV Epidemic*, op. cit., p. 6.

136 P.G. Barnett, "The cost-effectiveness of methadone maintenance as a healthcare intervention," *Addiction* 94(4) (1999): 479–488.

137 The Model List of Essential Medicines is meant to guide health policy-makers in knowing what medicines are necessary to ensure the health of their populations: *WHO Model List of Essential Medicines*, online via www.who.int/medicines/publications/essentialmedicines/en/. Methadone and buprenorphine were added to the list by the WHO's expert committee in July 2005.

138 WHO/UNODC/UNAIDS, *Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, 2004.

139 Malinowska-Sempruch et al., op. cit., p. 6.

140 Leading Russian government advisors such as Edouard Babayan played a significant role in the drafting of the *1961 Single Convention*. Babayan was for some three decades the representative of the USSR and subsequently Russia to the UN Commission on Narcotic Drugs (and the Commission's chairman in 1977 and 1990), and a long-standing member of the International Narcotics Control Board (INCB). He subsequently authored the schedules under Russian drug law that deemed even miniscule quantities of prohibited drugs to be "large" or "extra-large", thereby attracting years-long prison sentences for possession of such small amounts: L. Levinson, "Half a gram and thousands of lives," *Harm Reduction Russia Newsletter 2006-07* [English compilation], pp. 9-11, online: www.harmreduction.ru/files/harm_reduction_russia_2006-2007_eng.pdf. In Babayan's view, "those suffering from drug and alcohol addictions violate societal moral standards on purpose, voluntarily bringing themselves to the state of sickness. That is why society's actions towards these people can not be the same as actions on medical assistance to other categories of patients": cited in M. Maskas, "Trafficking drugs: Afghanistan's role in Russia's current drug epidemic," *Tulsa Journal of Comparative & International Law* 2005; 13: 141 at p. 16.

141 *Constitution of the Russian Federation*, 12 December 1993, Article 15(4).

142 *Criminal Code of the Russian Federation*, Federal Law No. 63-FZ of 13 June 1996; *Law on Enforcement of the Criminal Code of the Russian Federation*, Federal Law No. 64-FZ of 13 June 1996; *Law on Narcotic Drugs and Psychotropic Substances*, Federal Law No. 3-FZ of 8 January 1998.

143 *Law on Narcotic Drugs and Psychotropic Substances*, ibid. Article 1 of the Law sets out definitions of narcotic drugs, psychotropic substances and precursors, as substances included in Schedules in accordance with Russian legislation, international treaties of the Russian Federation, and the 1961, 1971, and 1988 UN Conventions.

144 *See* M. Maskas, "Trafficking Drugs: Afghanistan's Role in Russia's Current Drug Epidemic," *Tulsa Journal of Comparative & International Law* 2005; 13: 141 at p. 173.

145 Unofficial translation of excerpt from remarks by Minister of Interior Boris Gryzlov at the State Duma on October 17, 2001, available online in Russian at http://gryzlov.ru/index.php?page=publications&id=21.

146 Unofficial translation of excerpt from E. Babayan and A. Gaevsky "Particularities of the legal status of schedules of narcotic drugs and psychotropic substances: Establishment, amendment and implementation" in E. Babayan, A. Gaevsky, E. Bardin, "*Legal aspects of trafficking of narcotic, psychotropic and poisonous substances and precursors,*" [Особенности правового статуса списков наркотических средств и психотропных веществ: формирование, изменение, применение» в «*Правовые аспекты оборота наркотических, психотропных, сильнодействующих, ядовитых веществ и прекурсоров*»] 2000, p. 32.

147 Ibid., p.40.

148 Ibid., p.42.

149 Malinowska-Sempruch et al., op. cit.

150 Statement by V. Putin, President of the Russian Federation, Webcast of 6 July 2006, excerpt available (in Russian) at http://www.narkotiki.ru/ocomments_6307.html. The Service was constituted by the Decree of the President of the Russian Federation on "*Issues of Federal Service of the Russian Federation on Control over Drugs*

Circulation," Decree No. 976 of 28 June 2004 (last amended by the Presidential Decree No. 956 of 31 August 2006).

151 See the website of the Federal Service on Control over Drugs Circulation at www.fskn.gov.ru; and the companion site sponsored by the Federal Service at www.narkotiki.ru.

152 Decree of the President of the Russian Federation "*On additional measures against illicit trafficking in narcotic drugs, psychotropic substances and precursors,*" Decree No. 1374 of 18 October 2007.

153 V. Ivanov, "We have a strong enemy – the fight with it should be conducted as in a war – tough and without mercy" [" нас сильный противник, борьба с ним должна вестись как на войне –жестоко и беспощадно"], June 2008, online: http://www.narkotiki.ru/internet_6591.html.

154 *Guiding principles and directions of counteraction of illegal narcotics and psychotropic substances and abuse of them for the period until 2008*, Decision of the Meeting of Members of the Security Council of the Russian Federation, 29 June 1999. [Руководящие принципы и основные направления деятельности в Российской Федерации по противодействию незаконному обороту наркотических средств и психотропных веществ и злоупотреблению ими на период до 2008 года. Утверждены решением совещания членов Совета Безопасности РФ 29 июня 1999 г.].

155 Unofficial translation, ibid.

156 Ibid.

157 Ibid.

158 Ibid. The reference here is to the CIS model law on drug trafficking drafted by Russia and adopted by the CIS Inter-Parliamentary Assembly in 1996; it is described in more detail in the next section.

159 Russian criminal law provides for up to 20 years' imprisonment for illegal manufacturing, sale or mailing of narcotic drugs, psychotropic substances and analogues, if committed: a) in an organized group; b) in an official capacity; c) in relation to a minor under 14 years old; or d) in large quantities: *Criminal Code of the Russian Federation*, No 63-FZ of 13 June 1996, Article 228.1.

160 Interview with President V. Putin, 6 July 2006, online: http://www.narkotiki.ru/ocomments_6307.html (unofficial translation).

161 Federal Law "*On amendments to the Criminal Code of the Russian Federation,*" No. 162-FZ of 8 December 2003.

162 Resolution of the Government of the Russian Federation "*On amounts of average doses of narcotic drugs and psychotropic substances for the purposes of Articles 228, 228(1) and 229 of the Criminal Code of the Russian Federation,*" Resolution No. 231 of 6 May 2004.

163 Federal Law "*On amendments to the Criminal Code of the Russian Federation*" (2003), op. cit.

164 Lev Levinson, "*Drug policy reform in Russia: turn backwards*" (in Russian) on http://www.hand-help.ru/doc6.html, and other materials on Russian drug policy (in Russian) on http://www.hand-help.ru/doc8.html.

165 Resolution of the Government of the Russian Federation "*On large and extra-large amounts of narcotic drugs and psychotropic substances for the purposes of Articles 228, 228.1 and 229 of the Criminal Code of the Russian Federation,"* Resolution No. 76 of 7 February 2006.

166 The concepts in the *Criminal Code* of "large" and "extra large" amounts of drugs remain, however the definition of these amounts is no longer based on some multiple of an "average dose," as that concept has been abolished. Rather, new quantities of the actual amount of the drug have been specified in the 2006 resolution (Resolution No. 76 of 2006) as the threshold amounts. To take the example of heroin, under the 2003 legislative amendments passed by the Duma, an "average dose" was defined as 0.1g, meaning that a "large" amount was 1g (10 average doses) and an "extra large" amount was 5g (50 average doses). Following the 2006 resolution, currently any amount over 0.5g of heroin constitutes a "large" amount and any amount over 2.5g constitutes an "extra large" amount. Re-setting these threshold amounts for triggering criminal liability lower than the Duma's 2003 amendment is a step backward in reinstating a stricter form of prohibition; however, it should also be

noted that the net effect is to have raised the threshold from the exceedingly low threshold amounts originally set out in the original "Babayan table" (see note 59 above).

167 Presentation by A.V. Fyodorov at the meeting of the CIS Inter-Parliamentary Assembly on "Development of cooperation of CIS member states in the fight against illegal drug trafficking," in *IPA Bulletin* 2007; 1: 260-264.

168 Ibid.

169 Unofficial translation, "Drug control police intends to treat addicts compulsorily; Human rights activists rage against," 26 June 2007, News agency *Newsru.com*, [«Наркоконтроль намерен принудительно лечить наркоманов. Правозащинтики против»] online: www.newsru.com/russia/26jun2007/narkoman.html.

170 Unofficial translation, Viktor Cherkesov, interview of the former chief of the Federal Service of Control over Drugs Circulation (Mikhail Falaleev), "Breaking the drug system/how to combat drug money laundering," *Rossiskaya Gazeta* No. 4609 of 12 March 2008, online: http://rg-new.w-m.ru/2008/03/12/cherkesov.html [Ломка наркосистемы/ Как победить легализацию наркодоходов] (in Russian) and other articles on the media section of the website of the Federal Service of the Russian Federation on Control over Drugs Circulation: www.fskn.gov.ru/fskn/press-slujba/publik.htm.

171 Currently, CIS Member States include Azerbaijan, Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, and Uzbekistan. Ukraine, although it signed the agreement in 1991 that originally created the CIS and participates in the work of the CIS, is not legally a member, not having ratified the CIS Charter adopted in 1993. Turkmenistan reduced its status to "associate member" in 2005. In August 2008, Georgia notified the CIS of its decision to withdraw its membership, to take effect in one year's time under the terms of the CIS Charter.

172 The CIS Charter, adopted by the Council of Heads of States on 22 January 1993, stipulates the goals and principles of the Commonwealth, rights and obligations of the countries. The CIS, according to the Charter, serves to further develop and strengthen relations of friendship, good neighborhood, inter-ethnic accord, trust and mutual understanding and cooperation between states: CIS website, http://cis.minsk.by/main.aspx?uid=3360.

173 The plenary sessions of the IPA take place twice per year in St. Petersburg. The parliamentary delegations include heads of national parliaments, representatives of the CIS agencies, and observers from international and national organizations. Legislative acts and recommendations adopted at the sessions of the IPA are sent to the national parliaments for use in drafting new and amending current national legislation. The decisions of the IPA are adopted on a consensus basis: CIS IPA website, www.iacis.ru/html/index-eng.php?id=50.

174 "About CIS Inter-Parliamentary Assembly," online: www.iacis.ru/html/index-eng.php?id=50.

175 *Model Law on the Prevention of Illegal Traffic in Drugs, Psychotropic Substances and Precursors* (2 November 1996), [hereinafter "1996 CIS model law"]; *Model Law on Narcotics, Psychotropic Substances and their Precursors* (16 November 2006), Resolution No. 27-6 [hereinafter "2006 CIS model law"]; both available online in Russian via www.iacis.ru/.

176 CIS Report to CND (2008), op. cit.

177 *Concept of Cooperation of CIS Member States for activities to combat illicit trafficking in narcotic drugs, psychotropic substances and precursors*, adopted by the Decision of the Council of CIS Member States of 7 October 2002.

178 CIS Report to CND, 2008, op. cit.

179 This Joint Commission includes representatives of the Commonwealth parliaments, members of the CIS' IPA Permanent Commission of Defense and Security Issues, and representatives of law enforcement bodies of the CIS Member States and inter-state Commonwealth agencies.

180 S.M. Mironov, Speech at the opening of the 2005 Conference on International Cooperation on the Sphere of Fight Against Drug Dependence and Illegal Drug Trafficking, November 17, 2005. In *IPA Bulletin* 1'06, page 49. See also information provided by CIS' IPA: http://www.iacis.ru/html/index-eng.php?id=90&nid=34**.**

181 *Law on narcotic drugs and psychotropic substances*, Article 40.

182 The Russian Federation's *Administrative Code* punishes drug use with a fine: Article 6.9. There is no criminal punishment for drug use *per se*.

183 *Law on narcotic drugs and psychotropic substances*, op. cit., Article 31.

184 Unofficial translation, 2006 CIS model law, Article 36.

185 Unofficial translation, 1997 Russian law, Article 46 and 2006 CIS model law, Article 49.

186 Recommendations "*On Implementation of the UN Drug Control Conventions in the National Legislation of the CIS Countries,*" in Resolution of the Council of the IPA CIS Member States, "Concluding the international seminar on 'Implementation of UN Drug Control Conventions in the national legislation of the CIS countries' and on the international conference on 'Improving cooperation of CIS member-states in the area of combat of international terrorism and its financing,'" Resolution No. 13, St. Petersburg, Russian Federation, 16 June 2003 [hereinafter "CIS 2003 Recommendations"].

187 Ibid., preamble.

188 *Program of Cooperation of CIS Member States in the fight with illegal trafficking in drugs, psychotropic substances and precursors for 2005-2007*, Decision of the Council of Heads of Member States of the CIS, 16 September 2004.

189 Ibid., section 1.2.3.

190 *Declaration of the International Conference on International Cooperation in the Sphere of the Fight Against Drug Dependence and Illegal Drug Trafficking*, 17 November 2005, *IPA Bulletin* 2006; 1: 160 [Декларация Международной научно-практической конференции по проблемам международного сотрудничества в борьбе с наркоманией и незаконным оборотом наркотиков, 2006]. Information available in Russian at www.iacis.ru/html/?id=19&nid=59.

191 *Recommendations on unification and harmonization of legislation in the area of combating trafficking of narcotic drugs, psychotropic substances and precursors*, in CIS IPA Resolution "*On IPA CIS activities on harmonization of national legislation of CIS countries and on implementation of the intergovernmental plans of CIS on combat of terrorism and other extremist activities, crime, illegal trafficking of drugs, psychotropic substances and precursors,*" Resolution No. 27-6, 16 November 2006 [hereinafter "CIS 2006 Recommendations"].

192 A.G. Eritsyan, *IPA Bulletin* 2006; 1. p. 77.

193 A.V. Fyodorov, IPA Bulletin 2006; 1: 102.

194 V.A. Ozerov, Speech to the CIS Inter-Parliamentary Assembly, *IPA Bulletin,* 2006; 1: 101.

195 Armenia, Belarus, Kazakhstan, Kyrgyzstan, Russia, Tajikistan, and Uzbekistan are currently members of the Collective Security Treaty Organization.

196 CSTO Decision "*On strengthening measures to combat drug dependence and drug trafficking as financial basis of transnational organised crime,*" 28 April 2003, Dushanbe, Tajikistan.

197 *Kazakhstan: strengthening efforts in the fight against drug-business is a priority*, Information agency Kazinform, [*Казахстан: Консолидация усилий в борьбе с наркобизнесом является первоочередной задачей*, ИА "Казинформ"], 26 May 2008, online: www.narkotiki.ru/news_27566.html.

198 Координационный совет руководителей компетентных органов по противодействию незаконному обороту наркотиков (КСОПН).

199 "*On the results of the first stage of International investigatory-preventative operation "Kanal-2008*" [Об итогах первого этапа международной оперативно-профилактической операции «Канал-2008»], September 2008 (in Russian) on www.narkotiki.ru/gnk_6615.html (last accessed 11 November 2008).

200 Ibid.

201 Current members of the SCO include China, Kazakhstan, Kyrgyzstan, Russia, Tajikistan, and Uzbekistan. The main goals of the SCO are: strengthening mutual confidence and good-neighborly relations among the member countries; promoting their effective cooperation in politics, trade and economy, science and technology, culture and education, energy, transportation, tourism, environmental protection and other fields; making joint efforts to maintain and ensure peace, security and stability in the region, to move toward the establishment of a new, democratic, just and rational political and economic international order: www.sectsco.org/html/00026.html.

202 N. Nazarbaev, *Important results have been reached in the process of development of the SCO*, Xinhua, 29 June 2006 [Н. Назарбаев: *В процессе развития ШОС достигнуты важные результаты,* Агентство Синьхуа] (in Russian).

203 *Agreement between the Shanghai Cooperation Organization Member States on cooperation on combat of illegal trafficking in drugs, psychotropic substances and precursors*, Tashkent, Uzbekistan, 17 June 2004.

204 There is no explicit prohibition of non-medical drug *use* in the specific statutes on narcotic drugs of Uzbekistan, Kazakhstan, and Kyrgyzstan. Tajikistan does have specific law that state a prohibition on drug use, but no particular penalty is defined in the law or in the Administrative or Criminal codes. On the contrary, the *Code of Kazakhstan on Administrative Offenses* (30 January 2001, No.155-2, Article 336-2) and the *Code of Kyrgyzstan on Administrative Liability* (4 August 1998, No. 114, Article 366) prohibit drug use in public spaces and punish it with a fine.

205 In each of the countries in question, there is legislation allowing for compulsory drug treatment both inside and outside of prisons. In Tajikistan, compulsory drug treatment has not been implemented outside of prisons, due to lack of funding. In Kyrgyzstan, fewer than 10 patients were in compulsory treatment outside of penitentiary settings, according to UNODC data from 2007.

206 In Russian and Kazakh law, the provisions are almost identical in defining "propaganda" very broadly (including dissemination of books, other media products, and internet information): Article 46 of the Russian law "*On Narcotic Drugs and Psychotropic Substances*"; Article 24 of the Law of Kazakhstan "*On Narcotic Drugs, Psychotropic Substances and Precursors.*" The prohibition is more narrowly defined in the legislation of Kyrgyzstan, Tajikistan, and Uzbekistan.

207 *Agreement between the Shanghai Cooperation Organization Member States on cooperation on combat of illegal trafficking in drugs, psychotropic substances and precursors*, Tashkent, Uzbekistan, 17 June 2004. Article 1.

208 Ibid., Article 2.

209 SCO website: www.sectsco.org/home.asp?LanguageID=2.

210 UNGASS Resolution 61/183 (13 March 2007), UN Doc. A/RES/61/183, para. 1. See also, for example, the previous year's resolution UNGA Resolution 60/178 (22 March 2006), UN Doc. A/RES/60/178, para 1.

211 CND Resolution 51/12, Commission on Narcotic Drugs, Report on the Fifty-first Session, ECOSOC Official Records, Supp. No. 8, UN Doc. E/2008/28, E/CN.7/2008/15, at p. 32.

212 Article 1 of the Law of Kazakhstan "*On Narcotic Drugs, Psychotropic Substances, Precursors and the Measures to Counteract Illicit Drug Trafficking and Abuse*", Law No. 279-1 of 10 July 1998.

213 Article 2 of the Law of the Republic of Tajikistan "*On Narcotic Drugs, Psychotropic Substances and Precursor*s," Law No. 874 of 10 December 1999.

214 Article 1 of the Law of Kyrgyzstan "*On Narcotic Drugs, Psychotropic Substances and Precursors,*" Law No. 66 of 24 April 1998 (subsequently amended by Law No. 90 on 4 July 2005).

215 E.g., Article 2 of the Law of the Republic of Uzbekistan "*On Narcotic Drugs and Psychotropic Substances,*" Law No. 813-1 of 19 August 1999; Article 3 of the Law of Kazakhstan "*On Narcotic Drugs, Psychotropic Substances, Precursors and the Measures to Counteract Illicit Drug Trafficking and Abuse,*" Law No. 279-1 of 10 July 1998.

216 E.g., Article 3 of the Law of the Republic of Tajikistan "*On Narcotic Drugs, Psychotropic Substances and Precursors*", op. cit.; the Law of Kyrgyzstan "*On Narcotic Drugs, Psychotropic substances and precursors,*" op. cit., the Law of Kazakhstan "*On Narcotic Drugs, Psychotropic Substances, Precursors and the Measures to Counteract Illicit Drug Trafficking and Abuse,*" op. cit.

217 Kazakhstan (10 July 1998, with amendments of 2006); Kyrgyzstan (24 April 1998, with amendments of 4 July 2005), Tajikistan (10 December 1999), Uzbekistan (19 August 1999, most recent amendments of 10 October 2006).

218 Op cit.

219 For example, Articles 24-29 of the Uzbek law repeat Articles of the 1997 Russian law. Article 35 of the Uzbek law "on drug testing" repeats Article 44 of the Russian law, while Article 36 of the Uzbek law, imposing limitations on the rights of people dependent on drugs, is essentially the same as Article 45 of the 1997 Russian law.

220 Some of the provisions referred to in Table 3 are not necessarily enforced.

221 Interview with the Director of National Drug Monitoring and Prevention Centre of Tajikistan Soulkhiddin Nidoev, 11 October, 2008, Dushanbe, Tajikistan.

222 R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2nd ed. (Toronto: Canadian HIV/AIDS Legal Network, 2006), online via www.aidslaw.ca/prisons, pp. 41ff.

223 http://www.unic.ru/bill/?ndate=2007-07-17.

224 *Methadone therapy method for treatment of drug dependent will be studied in Tajikistan,* 2 October 2007, at www.regnum.ru/news/893523.html [в Таджикистане изучат метод метадоновой терапии для лечения наркозависимых людей] (in Russian).

225 M. Khidirov & M. An, "Human rights through the lenses of drug dependence in Tajikistan," in K. Malinowska-Sempruch, S. Gallagher & V. Djuma (eds.), *Drug Policy, HIV/AIDS and Human Rights* New York: International Debate Education Association, 2004 (Russian language edition), at p. 184.

226 D. Wolfe, *Pointing the Way: Harm Reduction in Kyrgyz Republic* (Harm Reduction Association of Kyrgyzstan, Open Society Institute and Soros Foundation Kyrgyzstan, 2005).

227 Resolution of the Government of the Republic of Kyrgyzstan "*On narcotic drugs, psychotropic substances and precursors under control in Kyrgyz Republic,*" Resolution No. 543 of 9 November 2007.

228 I. Isakov, "Drug policy must take into account local situation," *Word of Kyrgyzstan*, 24 April 2007, online at www.sk.kg/index.php?newsid=2122 (website of the Drug Control Agency of Kyrgyzstan) (unofficial translation).

229 Cited in the Interview with General B. Nogoibaev, director of the Kyrgyz Drug Control agency. "Do not push a person who uses drugs underground" ["Не загонять наркомана в подполье"], 24 November 2005, at the site of the Kyrgyz Drug Control Agency, http://www.dca.gov.kg/modules.php?name=News&file=article&sid=21.

230 President Nursultan Nazarbaev, Address to the Nation: "Kazakhstan 2030: Prosperity, security and improvement of well-being all people of Kazakhstan" (1997), available (in Russian) at the official site of the President of Kazakhstan, online:
www.akorda.kz/www/www_akorda_kz.nsf/sections?OpenForm&id_doc=DD8E076B91B9CB664625723400 19E60B&lang=ru.

231 Law of the Republic of Kazakhstan "*On amending the Criminal Code, Criminal Procedure Code and Administrative Code in relation of toughening liability in the area of illegal drug trafficking,*" Law No. 50-4 of 27 June 2008.

232 Online interview with the Deputy Minister of Internal Affairs of Kazakhstan, Oleg Feodorov (in Russian), on the website of the Ministry of Internal Affairs of Kazakhstan, online:
www.mvd.kz/index.php?p=conf_group&id_group=85&lang=1 (last accessed 11 November 2008).

233 Wolfe & Malinowska-Sempuch, op. cit, pp. 24-25.

234 *Unintended Consequences*, op. cit., p. 10.

235 Comprehensive and well-documented models of legislative provisions in this area have been developed and, as of this writing, have been adopted by bodies such as UNODC and national expert teams in all of the Central Asian republics as a touchstone reference for assessing existing laws affecting the HIV response among people who inject drugs and prisoners and identifying possible reforms to strengthen that response in light of human rights principles and evidence of effective health protection and promotion practices: e.g., Canadian HIV/AIDS Legal Network, *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, op. cit.

A member of Mexico's Federal Investigative Agency arrests a woman on suspicion of drug possession during an antinarcotics operation in Guadalajara. Hector Guerrero/Reuters

The Impacts of the Drug War in Latin America and the Caribbean

Diana Rossi, Shana Harris, and Marcela Vitarelli-Batista[236]

Drug policies in several countries of Latin America and the Caribbean have been influenced by the regions' neighbor to the north, the United States. Pressures to eradicate drug production have resulted in human rights violations of coca farmers and surrounding communities, and have not stemmed the tide of cultivation. At the same time, punitive approaches to drug use have failed to reduce demand. Though there is evidence that HIV is associated with drug use throughout the region, drug policies based heavily on law enforcement often deter people from seeking and accessing health services. People who use drugs also face human rights abuses, including police violence and threats to their health due to lack of disease prevention and treatment measures. Many are imprisoned on drug-related offenses, and with most prisons in the region filled beyond capacity but lacking measures to prevent the spread of disease, people are at heightened risk for HIV, hepatitis, tuberculosis, and other life-threatening conditions.

The situation is not completely bleak: Some countries have begun to include harm reduction measures in their public policies. Until drug control and public health measures are brought into harmony, however, injection-driven HIV epidemics in Latin America and the Caribbean will continue to grow.

Drug use and HIV in Latin America and the Caribbean

The geographic location of Latin America and the Caribbean makes the region important in the transshipment of drugs bound for U.S. and European markets,[237] especially cannabis and cocaine. Local markets have developed as a result of these trafficking routes, with the most commonly consumed drugs being cannabis, cocaine, alcohol, and tobacco.[238] Additionally, poppy fields in Mexico and Colombia provide the raw material for heroin production.[239] Heroin injection is found in Mexico, particularly in the north of the country along the U.S.-Mexico border,[240,241,242,243,244] and to a lesser extent in Colombia.[245] Overall though, cocaine, which is cultivated, refined, and shipped throughout Latin America and the Caribbean, is the primary injected drug in the region.[246,247,248,249]

Injection drug users in the region

The largest populations of injectors in Latin American countries are in Brazil, Mexico, and Argentina with some 800,000, 96,232, and 40,600 injectors respectively.[250] However, estimates in the region vary widely. Other researchers have put the number of injection drug users in Brazil at 196,000[251] and the number in Argentina at 64,558[252]. Despite the discrepancies in estimates, it is known that cocaine use overall has increased in recent years,[253] and cocaine injection is most prevalent in southern Brazil; Buenos Aires and Rosario, Argentina; and Montevideo, Uruguay.[254,255,256,257]

Injection drug use is particularly prevalent along the U.S.-Mexico border, where, in cities such as Tijuana and Ciudad Juarez, the injection of both stimulants and opiates is widespread.[258,259,260,261] Tijuana alone is home to more than 200 shooting galleries, where a growing population, currently estimated at 10,000 people, injects drugs.[262] In the city of Juarez, there were approximately 6,000 IDUs in 2001, including 3,000-3,500 "heavy" heroin injectors.[263,264]

The extent of injection drug use in the Caribbean is difficult to determine, due to a lack of available data. Injection drug use is so uncommon in the English-speaking Caribbean that treatment centers located there rarely if ever report an injector presenting for treatment. However, in the Spanish-speaking Caribbean islands of Puerto Rico and the Dominican Republic, injection drug use is much more common. In Puerto Rico, the island in the region with the highest IDU population, there are an estimated 15,000 people who inject drugs.[265] The San Juan metropolitan area alone is home to some 13,500 IDUs.[266] In the Dominican Republic, it has been estimated by treatment providers that 20 percent of those who present for treatment are injection drug users.[267]

HIV seroprevalence among drug users

Injection drug use plays an important role in HIV transmission in several countries throughout the region, including in Brazil where HIV prevalence among IDUs is between 28-42 percent and Argentina, where HIV prevalence among IDUs is between 18.8-39.2 percent; in Argentina an elevated HIV prevalence of 6.3 percent is also seen among non-injecting cocaine users.[268,269]

In Uruguay, where prevalence among IDUs is reportedly 24.4 percent, a recent study also stated that "unlike in other Latin American countries, the relative number of female injection drug users is high in Uruguay, with an increasing number of HIV infections among pregnant women and newborns of drug-injecting mothers."[270] HIV prevalence among IDUs in Paraguay's capital is reportedly 12 percent.[271]

In Mexico, the HIV prevalence has remained low since 1998; it is estimated at 0-6 percent among IDUs nationwide, and at 2.8 percent among IDUs in Tijuana and Ciudad Juarez as of 2007.[272,273] However, as researchers studying injection drug use in Tijuana and Ciudad Juarez have warned, the prevalence of hepatitis C among these communities of IDUs was 95 percent and the use of injection drugs on the border has increased steadily since 1998, making complacency about HIV infection dangerous.[274] Several studies have documented the rapid spread of HIV among IDUs when prevention methods are unavailable.[275]

While HIV prevalence rates are high in the Caribbean, the virus is spread mainly through sexual contact.[276,277] Puerto Rico is an exception; here the majority of new HIV cases are associated with injection drug use.[278] Various studies show HIV prevalence among IDUs in the capital of San Juan ranging from 28.8 percent to 55.2 percent.[279,280,281]

There is also evidence of a connection between non-injecting drug use and HIV in the Caribbean, where associations have been found between crack use and HIV. Lewis and Hospedales, reporting on research conducted in 1988 of crack cocaine users and HIV stated that "despite the absence of IV [intravenous] drug use in Trinidad and Tobago, drug users may be significant in the transmission of the HIV virus to and within the heterosexual population."[282] So, as early as 1991, research was published revealing a higher rate of HIV among this sub-group of drug users.

This is supported by studies in the United States that have shown that crack smokers have infection rates of HIV similar in magnitude to injection drug users.[283,284,285] Researchers have hypothesized that this association occurs through the mechanism of increased unsafe sexual practices precipitated by the use of crack.[286]

In Trinidad and Tobago, survey data has shown high HIV prevalence among crack users,[287] and a study in sexually transmitted disease (STD) clinics found that the strongest predictor for HIV infection was crack cocaine use.[288]

A further association between crack use and HIV has also been established in the Bahamas, where cocaine use among patients with an STD was significantly associated with HIV infection.[289]

In 2007, a behavioral surveillance survey of poor and indigent crack users conducted in Saint Lucia found a 6.8 percent HIV rate among crack-using men and an 11 percent HIV rate among crack-using women (with a small sample of 22 women). Significant was that a control group of poor and indigent people who do not smoke crack were also tested, and no HIV was found in that population.[290]

The United States has called combating drug trafficking, particularly from the Andean region and Mexico, a main foreign policy objective, and has directed as much as 50 percent of foreign policy assistance in the hemisphere toward this goal.

Despite the evidence above and other research, Caribbean crack cocaine users have not been included in regional or national HIV strategic plans. This is primarily attributed to the fact that Caribbean HIV strategies have been "donor driven." Donors have consistently stated that due to the lack of injecting drug use in the Caribbean, Caribbean drug users are not at risk.[291]

Governmental responses to drug use

The United States has called combating drug trafficking, particularly from the Andean region and Mexico, a main foreign policy objective, and has directed as much as 50 percent of foreign policy assistance in the hemisphere toward this goal.[292] The U.S.-led "war on drugs" remains a driving force in some of the region's drug control policies, particularly in Mexico and Colombia.[293,294] In Venezuela and Bolivia, changes in government have led to outright rejection of involvement by the United States Drug Enforcement Agency; in Brazil, the American approach is also losing ground and current policies are beginning to incorporate harm reduction principles.[295]

Where the United States, through military and financial support, has shaped national governments' counternarcotics strategies, drug control has focused primarily on supply reduction through the eradication of coca leaf plantations; the detention and punishment of drug traffickers; and the interception of drug shipments in campaigns such as Plan Colombia and the more recent Mérida Initiative.

Plan Colombia was first conceived by ex-Foreign Minister Augusto Ramirez Ocampo in 1998 as an aid initiative that would help end armed conflict in Colombia and support participatory social and economic development in the regions most affected by violence, illegal crops, or environmental issues.[296] The plan was developed under the leadership

of Ocampo and then-Colombian President Andres Pastrana Arango, but transformed under heavy U.S. influence[297] before the Clinton administration finally supported it in 2000 with $1.3 billion dollars.[298] In its final state, $860 million of the $1.3 billion dollars went to Colombia and three-quarters of that sum was designated to military and police forces.[299] The 2000 Plan "proposes a principally military strategy (in the U.S. component of Plan Colombia) to tackle illicit drug cultivation and trafficking through substantial military assistance to the Colombian armed forces and police."[300]

Such supply reduction initiatives in the Andean region have led to unanticipated shifts in drug use, including a proliferation of clandestine laboratories, where cocaine base paste, a cheaper and reportedly more addictive form of cocaine, is produced; this increased production has been associated with increased physical harms as well as economic crises.[301]

In June 2008, the U.S. Congress approved the Mérida Initiative, a three-year, 1.6 billion dollar assistance package, including $400 million to Mexico and $65 million to Central America, to fight drug-related violence.[302] The initiative has been compared to Plan Colombia and experts on U.S. policy in the region consider it similarly misguided and overly reliant on military and police force, with few monitoring mechanisms, despite the fact that Mexican security units battling drug trafficking have been accused of serious human rights abuses.[303]

Bolivia's counternarcotics strategy is mainly supported by aid from the United States and has largely been shaped by American interests.[304] More recently, however, the Bolivian government has resisted the United States' drug war, resulting in swift punishment from the Bush administration for its "failure to cooperate in counternarcotics efforts."[305] U.S. President Bush effectively blacklisted the country by cutting its trade benefits under the Andean Trade Promotion and Drug Eradication Act.[306] The administration's suspension of Bolivia's trade preferences, an unprecedented action against the country, could result in the loss of 50,000 jobs and impact the Bolivian economy significantly.[307]

While U.S.-funded drug war efforts consistently fail to address demand reduction in the United States, they have also had little impact on achieving their stated supply reduction goals. For example, Plan Colombia has so far proven ineffective at reducing cultivation, and even the U.S. House of Representatives Appropriations Committee commented in 2008 that it is "disappointed to note that since the beginning of Plan Colombia in 2000 the amount of hectares of coca cultivated in Colombia has gone up, not down and the area involved in illicit drug production has increased by over 42 percent."[308]

While failing to achieve a reduction in supply, such efforts often generate social and political instability and contribute to human rights abuses of coca leaf cultivators. For example, there have been many documented cases in Bolivia, Colombia, Ecuador, and Peru where fumigation, security forces violence, or imprisonment related to antidrug cam-

paigns have directly and indirectly contributed to widespread abuses of cultivators and local communities.[309,310,311,312,313]

Plan Colombia's emphasis on crop eradication, which has to a large extent focused on aerial fumigation, has drawn its own criticism: The UN Committee on the Rights of the Child expressed concern about the risks posed to children by aerial fumigation in Colombia. It also noted that aerial spraying had impacts on food security because of the damage it does to food crops.[314]

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The UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health noted similar concerns following a visit to the Colombia/Ecuador border in May 2007, particularly noting the negative physical and mental health effects of aerial spraying of glyphosate along the border. He further commented on the terrifying effect on children of military helicopters that sometimes accompany the aerial spraying.[315]

Such policies have resulted in unintended environmental degradation, with coca crops being displaced rather than eradicated and virgin land being deforested.[316]

In Bolivia, U.S. aid has been used to support programs and policies that are implicated in human rights abuses, including lack of due process, prolonged detention, alleged torture, and impunity for both Bolivian and U.S. law enforcement officials who are accused of abuses.[317] More recent reports document U.S.-backed drug control efforts leading to reported deaths, mistreatment, and abuse of the local population, and arbitrary detentions by members of local security forces.[318] Reports also tie forced crop eradication by the government to violent protests, with both farmers and government forces dying in clashes.[319]

In addition to influencing responses to supply reduction, the U.S. "war on drugs" agenda has had an impact on policies aimed at demand reduction in several Latin American and Caribbean countries. In practice, this means promoting a largely punitive and abstinence-based approach to drug use, rather than a public health-oriented, harm reduction approach. There is a small but growing body of research documenting the health

An airplane fumigates coca and poppy plantations in Colombia. The pesticides used have been implicated in health defects and damage to food crops. J.B. Russell/Panos

impact—specifically the risk of blood-borne disease transmission—of harsh drug control policy in the region.

Human rights abuse of drug users in the region

Human rights abuses against people who use drugs in Latin America and the Caribbean have gone largely undocumented and while anecdotal accounts suggest that the abuse of drug users by police and health care providers is widespread in the region, there is a scarcity of published data to support these claims.[320]

There has been recent documentation of human rights abuses against drug users in Mexico, where, according to Human Rights Watch, police abuse—sometimes amounting to torture—keeps drug users away from HIV prevention services, even where government policies support such services. One informant stated that the police "routinely extort money and confessions from people who use drugs, sometimes using the mere possession of syringes as an excuse to harass or arrest drug users or outreach workers providing services to them."[321]

A 2004 study of injection drug users in Tijuana and Ciudad Juarez documented police violence toward IDUs specifically along the U.S.-Mexico border.[322] Most participants

Mexican mounted police in Ciudad Juarez check for needle marks on a suspected drug user. Police patrol the city's tourist and bar area in search of drug users and others they say give the city a bad name. Vanderlei Joe Raedle/Getty Images

reported that they or someone they were with had been beaten by police; female IDUs experienced gender-specific physical and sexual violence at the hands of officers.[323] Almost all respondents reported that police accepted or demanded payoffs, either from shooting galleries (locations where people go to buy and inject drugs, often after paying a fee for using the premises) or from individual drug users.[324] In the same study, IDUs reported that it was commonplace to be arbitrarily arrested and detained for up to 36 hours for being identified as a drug user and/or possessing a used or sterile syringe.[325]

The researchers identified multiple ways in which policing practices in these two cities were not only illegal but also may increase the risk of blood-borne infection among IDUs. These included: fear of police abuse or detention and arrest, leading to hurried and unsafe injection or use of shooting galleries (where syringes are more likely to be shared); and 36-hour detention involving painful withdrawal symptoms, which then increased the chances for high-risk behavior upon release.[326]

In 2005, a cross-sectional study of IDUs in the same region revealed that almost half the participants (48 percent) had been arrested for possessing an unused/sterile syringe and more than half the participants (57 percent) had been arrested for possessing

a used syringe.[327] The study found a direct relationship between arrests for syringe possession and use of syringes that had previously been used by someone else.[328]

The Brazilian government has made efforts to reduce human rights violations against drug users by supporting new legislation that gives drug users the right to seek treatment for drug dependence without harassment. However, the reality on the ground is that an indiscriminant drug war policy has a disproportionate impact on disenfranchised and vulnerable populations. Armed police storm *favelas* and shoot into densely populated areas, aiming to kill drug traffickers and often targeting and killing children recruited into trafficking gangs.[329] In the first six months of 2007, police reported 449 such killings and 60 police dead.[330] Extrajudicial killings are common, law enforcement officials receive complete impunity, and the body count is primarily young, impoverished, black men and boys.[331] According to research done between 2004 and 2006 by the *Observatório de Favelas*, of 230 youth ages 11 to 24 involved in drug trafficking, 46 had died after two years.[332] As Bastos et al. eloquently point out, policymakers have often responded to such violence by "simply increas[ing] the dose of the same medicine, reasoning that current dilemmas are not the consequences of mistaken drug policies, but rather the result of an insufficient dose of an already bitter pill."[333]

Brazilian law does not specifically address the legality of the possession of syringes and drug paraphernalia. Anecdotal reports exist regarding police using such items as evidence of illegal drug use in their antidrug raids.

Policies in practice: what services are available to drug users and what barriers remain?

Harm reduction and HIV prevention

In contrast to other countries in the region, since the 1990s, the Brazilian government has gradually adopted harm reduction policies that have led to a significant reduction of AIDS and HIV cases.[334,335,336,337] In 1994, the first publicly tolerated needle and syringe exchange program began in Brazil with funding from nongovernmental organizations and the World Bank; by 2006 there were about 150 programs in the country, operating primarily with funds from Brazil's Ministry of Health.[338]

However, harm reduction and drug control policies have often operated in tension with each other. The first needle exchange programs in Brazil were established during a time when the country's drug policies were becoming increasingly punitive, due to the influence of international drug treaties.[339] Because there were no specific legislative

A woman abandons her Rio de Janeiro neighborhood as a tank patrols the streets. Such incursions breed distrust of outsiders, including health workers. Caio Leal/AFP/Getty Images

provisions to uphold the legality of such programs, criminal investigations of public health officers in several cities took place. Though the cases were closed due to lack of evidence, the legal proceedings seriously disrupted the continuity of programs at that time.[340,341]

Police abuse continues to be an obstacle to harm reduction programs today.[342] Brazilian law, for instance, does not specifically address the legality of the possession of syringes and drug paraphernalia. Anecdotal reports exist regarding police using such items as evidence of illegal drug use in their antidrug raids.[343] Global experience shows that police raids often force drug users from one neighborhood to another, or may push needle exchange programs to new locations.[344] This can result in drug users not knowing where to find needle exchange sites. Furthermore, widespread police presence in Brazilian *favelas*, including raids with small tanks, has resulted in mistrust, with any outsiders seen as potential informants, making the work of public health workers more difficult.[345]

Though harm reduction is still a new and not entirely well-understood concept in the region, where it may be associated primarily with injectable drugs, which are only common in particular areas,[346,347] the concept has gained some momentum outside of Brazil, particularly in Argentina and Uruguay, where HIV/AIDS prevention programs are being instituted by national AIDS agencies and NGOs. Much of the success in implement-

ing needle and syringe exchange has been due to the work of civil society; this work has been implemented in Argentina, Uruguay, Mexico, and Puerto Rico without large-scale government assistance.

In one of those areas, specifically the border city of Tijuana, Mexico, stakeholders interviewed about the feasibility of three harm reduction interventions reported that structural and sociocultural challenges, such as the influence of the Catholic Church and lack of political will among government officials may hinder the implementation of harm reduction interventions.[348] In a recent study, only 38 percent and 30 percent of respondents in the respective cities of Tijuana and Ciudad Juarez had ever had an HIV test. The major barriers to HIV testing were social instability; mistrust; insufficient opportunities for testing in public and private settings; and a potential lack of awareness of HIV testing availability.[349]

In Ciudad Juarez there is one needle exchange program, the first in the country, which has operated there since the late 1980s and was opened by an NGO; the second program opened in 2004 in Tijuana.[350] For Juarez, with approximately 6,000 IDUs[351] and Tijuana, with a growing population of approximately 10,000 IDUs,[352] existing services are insufficient. Despite Mexico's Ministry of Health publishing a statement in support of syringe exchange, in 2006 there were reported to be only six small, largely NGO-run programs in the country.[353]

Negative attitudes on the part of health workers also deter drug users from seeking health care.[354] In Mexico, it is possible to purchase sterile syringes at pharmacies, but in areas of high drug activity, pharmacists sometimes refuse sale to those who appear to be drug users, claiming to have run out of syringes or by artificially raising prices.[355]

Though heroin injection is seen in Colombia, and cocaine injection is seen in other countries throughout Latin America, free, sterile syringes are unavailable.

In the English-speaking Caribbean, the Caribbean Harm Reduction Coalition has helped define what harm reduction looks like in a non-injecting environment, taking it beyond just needle and syringe exchanges and helping communities and individuals in the Bahamas, the Dominican Republic, Jamaica, Saint Lucia, and Trinidad to initiate and promote harm reduction education, interventions, and community organizations.[356]

Puerto Rico is home to the Caribbean's only needle and syringe exchange programs; the first program there opened in July 1995, sites have since opened in 13 communities around San Juan. However, syringe exchange has been as controversial in Puerto Rico as in the United States itself.[357]

Drug treatment programs

In 2007, 1,078,821 people accessed drug treatment across the region.[358] Drug users seeking rehabilitation treatment usually find this service offered by psychiatric clinics and/or

therapeutic communities. However, experts studying the status of epidemiology, service use and HIV research in Latin America, determined that data on treatment utilization or efficacy, was "virtually non-existent."[359]

Therapeutic communities use the idea of "community" as an essential component of treatment.[360] This modality creates a dynamic where the resident helps him or herself and others to achieve defined goals. Unfortunately, governments in the region have rarely developed good systems to evaluate the results of treatment or to address the protection of drug users' human rights while they receive treatment at these centers.

Abuses committed against drug users in treatment have been reported in the region. For example, two treatment facilities in Brazil were cited for the maltreatment of their residents between June 2007 and May 2008.[361] The use of chains and other forms of imprisonment to restrain persons dependent on alcohol and other drugs have been reported.[362]

In Brazil, most treatment centers employ an abstinence-based, 12-step approach that is often religious in nature.[363] In Argentina, the law states that drug users may be court ordered to complete compulsory treatment.[364] Most services are based on the model of abstinence and expect residents to discontinue all drug use.[365] However, there are some treatment centers in Argentina—as well as in Brazil and Uruguay—based on harm reduction principles.[366,367]

Throughout the Caribbean and due to the strong influence of the United States, drug treatment facilities generally use an abstinence-based model or a 12-step approach.[368,369] With the support of the European Union and the UK government, the Caribbean Harm Reduction Coalition has been successful in promoting easy-to-access, street-based harm reduction centers in the Dominican Republic, Trinidad, Jamaica, and Saint Lucia.

Medication-assisted treatment

While drug treatment in Latin America and the Caribbean is primarily focused on rehabilitation through abstinence, medication-assisted treatment for opiate dependence (with methadone or buprenorphine) is available in Mexico and Puerto Rico.

Though the availability of medication-assisted treatment has increased in recent years in Mexico, it still falls short of good coverage, with 3,644 people receiving treatment at 21 sites.[370] Methadone treatment is only available in select cities, including Tijuana and Ciudad Juarez,[371] though in Tijuana methadone is offered only in two privately owned centers;[372] buprenorphine is not available.[373]

In other countries in the region, medications to curb opiate cravings are largely unavailable because opiate consumption is relatively low, resulting in a low demand for

these medicines.[374] Nevertheless, pilot projects and services are available to drug users in some Argentinean cities.[375,376]

In contrast to the rest of the Caribbean where methadone is available only for pain relief, methadone treatment for drug dependence is available in Puerto Rico.[377] In addition to five methadone programs in the community,[378] the "Las Malvinas" men's prison expanded a pilot methadone program to include more than 300 inmates.[379] Buprenorphine is also available in Puerto Rico, by prescription.[380]

HIV treatment for people who use drugs

The lack of HIV/AIDS prevalence estimates among drug users in the region continues to be a barrier in assessing the needs for drug-related treatment. It is clear, however, that throughout Latin America and the Caribbean, antiretroviral treatment (ART) is still relatively difficult to access for HIV-positive drug users.

In several Latin American countries, including Argentina, Brazil, Colombia, Costa Rica, Cuba, Chile, Mexico, Peru, and Uruguay, ART is available through the public sector. Treatment, however, is not always free of charge, and collateral fees represent a particular barrier for IDUs. While there are no official policies preventing drug users from receiving ART, there continue to be informal difficulties for drug users seeking treatment in the region.

Study participants perceived violence related to police harassment as being more dangerous than the sexual and health risks of taking drugs.

A 2002 study done in Colombia found that lack of health insurance limited drug users' access to health care, including ART; additionally, study participants perceived violence related to police harassment as being more dangerous than the sexual and health risks of taking drugs.[381] This fear of harassment or arrest may prevent drug users from going to HIV clinics to receive medications, even if they have health insurance to pay for treatment.

In Brazil, Argentina, Mexico, and Uruguay, a main barrier to scaling up access to ART for people who use drugs is health care workers' attitudes and misconceptions.[382] For example, many health care providers fail to distinguish between different modes of use (dosage, frequency, and circumstances of drug use), judging all drug users by a single standard and often requiring that they seek abstinence-based drug treatment before beginning ART. Additionally, they may consider drug users to be self-destructive and unconcerned about their health.[383,384] In Argentina for example, the late AIDS diagnosis of most IDUs[385] is thought to be a result of the social distance between IDUs and the health care

system, often aggravated by the refusal of many Departments of Infectious Diseases to provide antiretroviral treatment to individuals who continue to use drugs.[386]

Studies have shown that, given the proper supports, drug users can be just as adherent to ART regimens as others and can achieve comparable treatment outcomes.[387] Latin America is no exception: in Brazil, for example, a study of active drug users in Sao Paulo found that 69 percent of patients had adherence levels of over 80 percent, though most were poor, had limited educations, and were unemployed.[388]

Brazil introduced universal access to ART in 1996, and has documented sustained reductions in HIV infections and AIDS cases among IDUs. Despite the success of this policy, issues of supply interruption and drug resistance have led to some concern regarding sustainability.[389] In 2005, Brazil's expenditure on ART increased by 66 percent due to the large number of persons receiving expensive second-line treatment given to those already resistant to some first-line HIV medications.[390]

In the English-speaking Caribbean, ART is free to all people living with HIV/AIDS who require it. The challenge in getting HIV positive drug users on medication lies more in resolving questions of access than in ensuring availability on paper.[391] Outside of a pilot project operated in Saint Lucia there are no outreach programs to test and treat crack users. In most territories the profile of a person diagnosed with advanced HIV disease is male, homeless and a drug user. This population makes up the majority of persons dying from AIDS-related illnesses in Saint Lucia.[392]

Incarceration of Drug Users

Prisons, which aggregate people at risk for HIV infection in contexts where high-risk behaviors continue but where means of protection such as clean needles are unavailable, function as HIV acceleration machines. While data is scant in Latin America and the Caribbean, the regions are likely no exception. The "war on drugs" there has led to an increase in the number of persons imprisoned on drug-related charges. Drug war policies adopted in the Caribbean with U.S. financial support, for example, led to the imprisonment of a large number of people who use drugs or associated with the drug trade, resulting in prisons filled beyond capacity.[393] Although it is difficult to prove conclusively the numbers of people who acquire HIV or other infections while in prison (due to ethical challenges and testing difficulties, many studies rely on mathematical models or statistical associations), it is known that the proportion of incarcerated individuals who are HIV positive or who have other infectious diseases is much higher than in the general community.[394]

While data on rates of those imprisoned for drug-related offenses is limited, the available evidence does suggest that drug war policies have had an impact on increased incarceration rates. Brazil is currently fourth in the world for total prison population,

A woman and her baby stand in their cell in a prison in Buenos Aires, Argentina. In 2008, 96 percent of the inmates in the prison had not received final sentencing; most were arrested for crimes against property or possession or sale of drugs. Carolina Camps/Reuters

behind only the United States, Russia, and China (all countries with punitive drug policies). Mexico ranks sixth in the world for total incarcerated population.[395] It remains to be seen if Mexico's incarceration rates will increase at a faster pace following the implementation of the Mérida Initiative.

Based on data from the International Centre for Prison Studies, the prison systems of all countries discussed in this chapter, except Puerto Rico, are overcrowded, with most filled far beyond their official capacity. During the last decade, the prison population in each of these countries, except Puerto Rico (which was already high, due to the U.S.-promoted war on drugs),[396] has dramatically increased.[397]

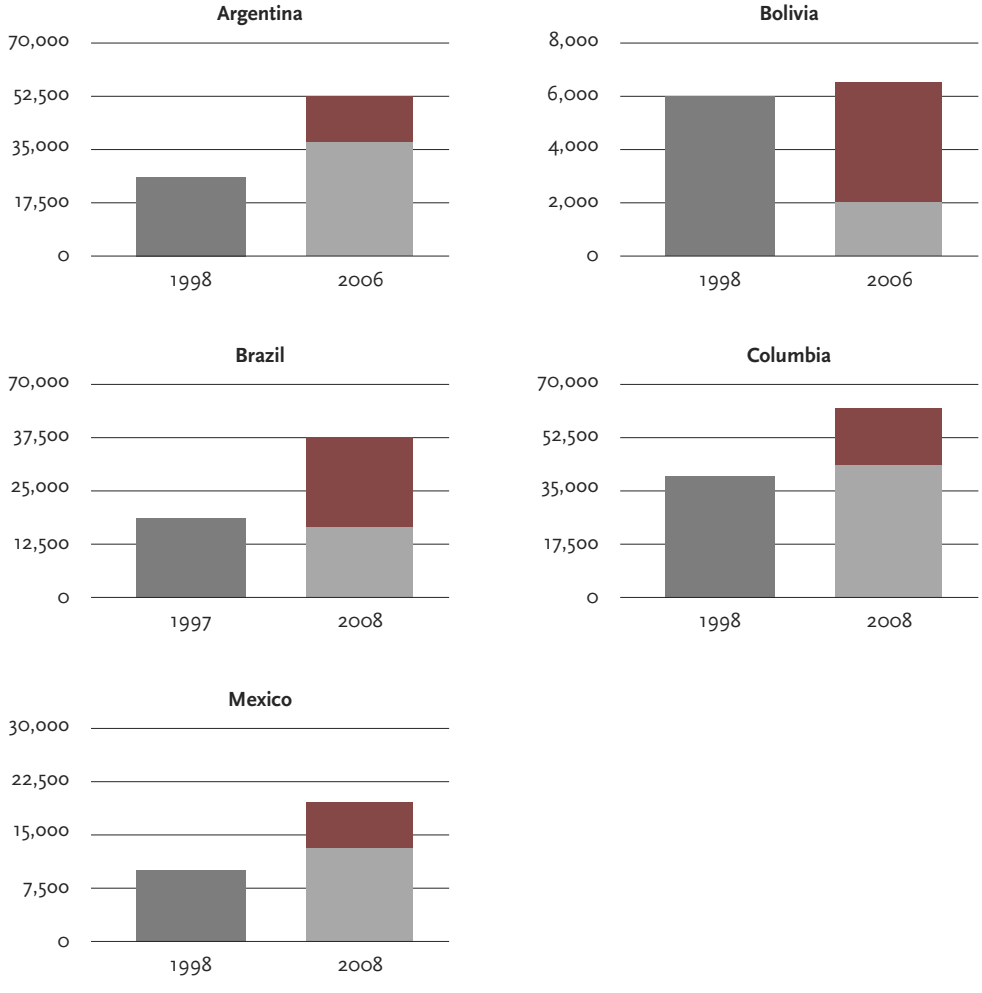
Prison overcrowding in select Latin American countries[398]

The graphs on the following page show the increase in prison population in select Latin American countries between roughly 1998 and 2008 (the years vary slightly, as indicated, given the available data). The red sections of the graphs show the proportion of the prison population in each country that is above the official capacity.

According to the World Prison Brief, in the period from 1998 to 2001, Colombia's prison population increased by 5 percent, while in the period from 2001 to 2004, it

Chart C. Prison overcrowding in select Latin American countries

The red sections of the graph show the proportion of the prison population in each country that is above the official capacity.



increased by 27 percent.[399] A significant portion of this increase may be a direct result of Plan Colombia, which was instituted in 2000: In the beginning of the decade, with the support of the United States under Plan Colombia, Colombia took an increasingly tough stance on drug offenses, and the incarceration rate for drug trafficking-related offenses skyrocketed by 322 percent in the two-year period between 2002 and 2004.[400] In the first six years of President Uribe's tenure (2002-2008), approximately 400,000 citizens have been detained for drug trafficking offenses and another 626 have been extradited.[401]

Healing the Split: Aligning Drug Control with Health and Human Rights

Very recently, countries such as Argentina, Bolivia, Brazil, Ecuador, and Uruguay have exhibited important changes in their national and international debates about drug policies.

Interestingly, in Argentina, the national government recently declared its willingness to change the laws supporting the decriminalization of drug possession for personal use. The current president, Cristina Fernández de Kirchner, said that those who have an addiction cannot be "condemned as if they were criminals."[402] This change began with the anti-prohibitionist declaration of Justice Minister Aníbal Fernández at the 51st session of the Commission on Narcotic Drugs, held in Vienna in March 2008. The declaration recommended "the proper integration of the United Nations human rights system with international drug control policy." This text was an initiative of the Uruguayan government and was co-sponsored by Bolivia, Argentina, Switzerland, and eventually by all of the European Union.[403]

In 2006, Brazilian law 11,343 stated that drug users and drug dependents should receive assistance oriented to social inclusion. Meanwhile, the Uruguayan government has been "installing a national debate on drugs regarding social and legal issues, which has provided the opportunity to implement social tolerance and a consensual deregulation. Humane and progressive treatment are the objectives in our policy, because a prohibitive phenomenon and the 'zero tolerance' drug policy have shown their failure."[404]

Ecuador's new constitution, approved in September 2008, states in article 364 that the addiction problem is a health system issue; it prohibits criminalization or violations of drug users' constitutional rights. Ecuador has designed an amnesty policy for dealers—called "mules" in the region—currently under debate. Those dealers are people who try to leave the country with a small quantity of illegal drugs to achieve economic benefits. The current president Rafael Correa pointed to the proportionality of punishment with the possibility of pardon, by reducing the number of years in prison if the crime is a first-time offense.[405]

In Bolivia, the current president Evo Morales' governmental policy is based on the integration of alternative development and against harsh antidrug laws that have harmed coca leaf producers' livelihoods and resulted in displacement and poverty.[406]

In the metropolitan area of Buenos Aires in Argentina, most of the imprisoned women are in jail for trafficking small quantities of illegal drugs. Their mean age is 30 years old and 90 percent of them have children.[407]

In 2006 the Brazilian government passed a new drug law that began to address proportionality in sentencing, differentiating possession charges and trafficking charges by offering alternatives to incarceration for possession, while continuing to send traffickers to prison with increased terms.[408] However, experts question how much control the state can exert over police interventions on the street, which are often illegal to begin with,[409] or how much impact the new law will have without reform of the judicial system.[410] When the law was still under discussion in the Senate, critics argued that it actually did little to distinguish between user and trafficker, giving no specific guidance about quantities that differentiate possession from trafficking and instead relying on subjective contextual evidence such as time or place of incident or conduct of the individual.[411] Furthermore, the law, lauded in the media for eliminating prison sentences for users, still allows judges to hand out prison time if individuals elect not to go to mandated treatment.[412]

Puerto Rico was one of only a few countries in the Caribbean/Latin American region where the total prison population decreased, by 11 percent between 1998 and 2007. The total prisoner count of 13,215 in December 2007 was 12 percent below official capacity.[413]

As with the general population, HIV infection is a serious public health problem for inmates in Latin America and the Caribbean, particularly in the Southern Cone and Puerto Rico.[414,415] High HIV prevalence in prisons—combined with HIV risk behavior—creates a critical public health issue for correctional institutions,[416] as well as for society at large. The inhumane conditions and inmate overcrowding observed in some prison systems perpetuate these health problems, and inmates are at constant risk of human rights violations.[417] In both Latin America and the Caribbean, data related to this problem are limited and difficult to access, though the figures available suggest the urgency of the need for HIV prevention and treatment.[418] In Argentina, for example, AIDS was the primary cause of death in prisons between June 2003 and June 2006.[419]

In Brazil, HIV prevalence in the country's prison system has been documented at between 12.5 percent and 17.4 percent.[420] One study in Brazil found that HIV transmission inside prisons is primarily due to injection drug use, and that risk of transmission increases with the length of time of imprisonment.[421] A series of studies have linked HIV, HCV and HBV infection in Brazil to individuals' history of incarceration.[422] Programs to prevent disease transmission are fragmentary or, in many key areas, absent altogether.[423]

In 2000, a study among male prisoners in two prisons in northern Mexico found a 2.53 percent HIV prevalence in one prison and a 1.8 percent HIV prevalence in another.[424] The same study showed a 37 percent prevalence among IDUs in one prison and a 24 percent prevalence in the other.[425]

As a result of the "war on drugs" policies of the 1990s, Caribbean prisons were filled beyond capacity and the region had one of the highest rates of imprisonment in the world.[426] The incarceration history of a cohort of recently released ex-inmates in Puerto Rico was significantly correlated with chronic drug use and seropositive HIV status. Therefore, correctional facilities must be equipped with HIV testing, treatment, and prevention services in order to decrease the rate of transmission within prisons.[427]

HIV care and treatment in the prisons of the English-speaking Caribbean is remarkably good compared to other countries of the hemisphere.[428] As mentioned, HIV treatment is free and this extends to the prison system. Two major challenges have been observed in providing care and treatment to incarcerated populations. First, given that the majority of prison populations in all the countries included are made up of crack users, and given the late identification of the virus among this population, many crack-using persons are only diagnosed with HIV when they are incarcerated and present at the prison infirmary with an opportunistic infection. At that point many inmates will be given ART (usually directly administered on a daily basis to ensure high levels of treatment compliance).[429] The second major challenge is that there is no active mechanism to follow up with HIV-positive inmates upon release, the expectation being they will go to the HIV clinic voluntarily for treatment. This has proven to be a false assumption and throughout the Caribbean the vast majority of formerly incarcerated HIV positive drug users are lost to treatment upon release.[430]

Conclusion

To date, the majority of the drug laws in Latin America and the Caribbean have centered on punishing drug users, and harm reduction laws still remain in the initial stages of development in many countries. Nevertheless, Brazil reaffirmed its position regarding harm reduction policies by supporting the need for different approaches in addressing the drug user, not only abstinence-based models.[431] Today, a challenge to Brazilian harm reduction includes changes in health financing: though Brazil has the highest number of syringe exchange programs in the region (at 93), the number of needles handed out is low, and these programs are generally concentrated in major urban areas.[432] Decentralization of health services means that local governments can choose whether or not to implement harm reduction policies, and many have yet to prioritize the approach.[433]

Elsewhere in Latin America, governments are discussing important changes to drug policies, including harm reduction principles (see box). Overall, there is much to do: unless governments in Latin American and the Caribbean change their policies to emphasize harm reduction and confront the social exclusion of drug users, the transmission of HIV and other infections among people who use drugs will continue to grow.

Notes

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Section III
Drug Control, Drug Use, and HIV: Reports from South and Southeast Asia

Young soldiers stand guard at a drug rehabilitation center in a former hospital in Mong Thien, Myanmar. John Vink/Magnum Photos

Civil Society Reflections on 10 Years of Drug Control in Myanmar, Thailand and Vietnam: A Shadow Report

Prepared by the Asian Harm Reduction Network (AHRN)[434]

Background

This chapter examines the effect of drug policies on injection drug users, particularly HIV prevention and care among users, and the availability and effectiveness of drug treatment services from 1998 to 2008 in Myanmar, Thailand, and Vietnam. While the chapter focuses mainly on civil society perspectives, the authors also contacted other key stakeholders to corroborate and contrast those views. The review incorporates the perspectives

of key civil society representatives including people who use drugs, as well as service providers, nongovernmental organizations, government officials working on HIV or drug control, and UN representatives, all of whom contribute to shaping national drug policies. In particular, the review concentrates on the results and impacts of the national drug policies in the three countries, especially in regard to HIV prevention; treatment and care amongst IDUs; and engagement of civil society. The report highlights with specific examples where civil society, governments, and the international community have supported public health and harm reduction initiatives, and areas where these efforts need more urgent attention.

This chapter also details various stakeholders' reflections on the challenges to implementation of a comprehensive national drugs strategy in each of the countries examined. Such an evidence-based strategy would be designed with significant civil society input; reflect a pragmatic approach to drugs that prevents the transmission of HIV and other blood-borne viruses; and promote equality across the health sector toward HIV treatment and care for drug users living with HIV/AIDS. In addition, given the key role of penal institutions in accelerating HIV transmission and the ineffectiveness of incarceration to address issues of drug use, such a strategy should lead to a reduction in the number of drug users in the criminal justice system and in custodial settings, while promoting and strengthening access to a wide range of effective, evidenced-based primary health care services, including drug treatment and HIV prevention options, all on a voluntary basis. No such system is currently found in the countries surveyed.

Methodology

Data was collected through a combination of focus group discussions, in-depth interviews, and through e-mail and online surveys. Respondents were selected in discussions with key stakeholders, local consultants, and AHRN staff. There were several challenges in the implementation of this project:

- In some cases, respondents were unaware or insufficiently informed about the national drug control policy to provide meaningful answers. Much time was spent explaining the national policy environment and mechanisms, rather than eliciting data for this report.
- Service providers/NGOs, government officers, and people who use drugs have different perspectives and opinions. The authors made a concerted effort to synthesize these into an overview that does justice to these differences.
- Particularly in Myanmar, obtaining permissions for interviews hampered data collection.

Unless otherwise specified, all statements, observations and perceptions outlined in this report have been collected from in-country focus group discussions, key informant interviews, and a survey questionnaire.

Myanmar

The unofficial sources recruited for this study reported that over the past 10 years, local supply and production of drugs has increased, particularly the production of amphetamine-type stimulants, though opium production has increased as well, despite attempts to eradicate poppy cultivation and local drug production. In Myanmar, the most commonly used drugs are heroin #4, a white powder that is arguably the purest and strongest heroin available, and stimulants, which are rapidly becoming popular among young people.

A 2007 population size estimate conducted by UNAIDS, WHO, the National AIDS Program and others put the number of IDUs between 60,000 and 90,000, with six non-injection drug users for every injector; the median HIV prevalence was estimated at 43 percent, with acknowledgment of percentages up to 70 percent in so-called "hot-spots" (places known for widespread drug use). HIV rates among IDUs have been consistently high in the past decade.[435]

Some insurgent groups who have signed ceasefire agreements with the Myanmar government are reportedly involved in drug production. Rumors indicate that some civil society groups might be exploring the possibility of supporting HIV prevention programs such as needle exchange for drug users, yet this is very hard to substantiate given the limited communications infrastructure and government censorship.

Key findings

The Myanmar drug policy is enshrined in the Narcotic Drugs and Psychotropic Substances Law of 1993 (Ministry of Home Affairs, Notification No. 1/1995, Yangon). The law provides a broad legal framework for the formulation and deployment of policies on drug control and HIV. Three layers of administration oversee the legal implementation through a national strategic plan: rehabilitation centers, run under the Ministry of Social Welfare, offer long-term residential behavioral correctional programs for six months to one year; drug treatment centers are entrusted with the operations of the nationwide 45-day detoxification process, conducted in closed, residential settings either on voluntary basis or imposed by law as an alternative to incarceration; and recently, rapid detoxification has been made available on a limited basis to people who qualify for methadone treatment, where qualification is based on protocols developed by the Ministry of Health, with support from WHO and other agencies.

The law distinguishes between, but criminalizes drug possession, drug dealing, drug trafficking, and possession of paraphernalia (limited to needle and syringes).

Women and drug use

According to drug user focus groups, up to 30 percent of drug users in Myanmar are female, with a significant proportion involved in sex work. This exacerbates women and girls' vulnerability to HIV and leads to higher levels of discrimination, stigmatization, and alienation by family members, their children, and the community because of the expectations for women to fulfill traditional gender roles. Nevertheless, currently less than 10 percent of those reached by community-based harm reduction services are female.

Incarcerated women have no access to childcare services and babies are often born without medical support; in addition, prevention of mother-to-child transmission (PMTCT) services are limited.

In the last 10 years, there have been no efforts to address issues and concerns related to female drug users. There are no women-specific drug treatment or rehabilitation centers catering to the specific needs of women and girls. Instead, the existing Drug Treatment Centers accept female drug users along with men. Punishment and imprisonment for drug-related offenses are not mitigated by gender. In prison there are limited health services, let alone ART.

There are currently no specific legal provisions for human rights or for harm reduction. Needle and syringe exchange programs and outreach services, which have been demonstrated to be effective in reducing transmission of HIV and other blood-borne viruses, are operating in a limited number of locations. Indeed, the tolerance of syringe exchange programs in some areas appears to have created confusion among law enforcement officials in regard to possession of paraphernalia. In those townships where community-based harm reduction services are operational, there are generally no arrests for possession of paraphernalia, yet there are reports that such arrests take place in other townships. Drug users and people living with HIV can legally form and register organizations and in the past two years, some self-support groups have started to form. However, there are currently no procedures or mechanisms to monitor and control law enforcement abuse, harassment, and beating either inside or outside of prisons.

The Central Committee for Drug Abuse Control (CCDAC), operating under the Ministry of Home Affairs, the Ministry of Information, the Ministry of Justice and the Ministry of Health, leads the implementation of the drug control policy through law enforcement measures. CCDAC's efforts toward supply reduction over the past ten years include increased arrests of producers, dealers and users, as well as poppy eradication, according to respondents. These efforts coincide with the objective of eliminating drugs in Myanmar by 2015, in line with one of the goals of the Association of South East Asian Nations (ASEAN).

CCDAC has also been instrumental in supporting harm reduction activities at pilot intervention sites. The CCDAC is guided by the 15 Year Drug Elimination Plan,[436] which outlines four priority activities: elimination of drug use through treatment, prevention of drug use, advocacy for community participation, and international cooperation.

Respondents report that arrests and police crackdowns have led to drug users switching from inhaling to injecting, increasing their risk of HIV transmission and other negative health consequences related to injection such as thrombosis and abscesses. Indeed, crackdowns and eradication of poppy fields have led to decreased availability of opium and heroin and, as such, injecting becomes cheaper for simple economic reasons. Law enforcement officials are expanding their efforts; this has also affected drug users' partners and families, and many respondents spoke of harassment and discrimination they suffered at the hands of law enforcement officials.

Arrests and police crackdowns have led to drug users switching from inhaling to injecting, increasing their risk of HIV transmission and other negative health consequences related to injection such as thrombosis and abscesses.

In many villages, reports abound of premature deaths among young incarcerated drug users, disappearances, and growing public health hazards due to the high HIV vulnerability and prevalence among injectors, although these reports are hard to substantiate through official sources. Local drug treatment services are extremely limited, and where available, generally consist of forced drug detoxification centers operated by village councils. These centers are often managed as boot camps, employing measures such as forced farm labor.

Many drug users end up incarcerated in dire conditions. Only the most basic health services are available in the country's 94 prisons.[437] Drug users in prison are often used as field laborers and assigned to agricultural duties and "labor camp therapy," many drug users have lost their lives in these prisons. Inadequate infrastructure and deprivation are common in prison settings where they lead to increased health and social risks. Given those risks, HIV transmission is perceived to be rapidly increasing and authorities are imposing mandatory testing, without counseling, of all prisoners, while antiretroviral treatment (ART) and treatment for opportunistic infections remain underdeveloped.

When drug users are identified as living with HIV/AIDS, they face a limited range of options. Provision of ART in Myanmar is largely restricted to three leading international NGOs – Médecins Sans Frontières, Aide Médicale Internationale, and Médecins du Monde. At present, approximately 6,000 of the estimated 160,000 who need it have

Drug users detox at a treatment center in Mong Pawk, Myanmar. Though some 30 percent of drug users in Myanmar are women, few services are targeted to them. John Vink/Magnum Photos

access to ART. However, in addition to those already enrolled in ART programs, a recent pilot project operated through the national AIDS program of the Ministry of Health has started a pilot ART project. Ultimately coverage is still very limited due to the small number of distribution sites. Although not officially excluded from ART programs, the number of IDUs receiving ART is very low and requires urgent scale-up. Community-based harm reduction service providers have managed to enroll IDUs in ART through collaboration with the NGOs providing the treatment.

In recognition of the spread of HIV among drug users, methadone was introduced in Myanmar in 2006 under the technical guidance of the World Health Organization. Methadone is currently offered at six of the 26 major and 40 minor government-run drug treatment centers.[43][8] Following in-patient treatment for approximately three weeks, methadone is provided to individuals on an outpatient basis in collaboration with community-based drug treatment services. In general, provisions for ART and methadone are extremely limited, if available at all. Unfortunately, stigma and discrimination toward drug users and people living with HIV is reportedly linked to low levels of HIV awareness and is fuelled by compulsory registration of drug users at drug treatment centers, thus limiting access to essential health services. The registration clause is relaxed in a few sites where harm reduction services are being delivered.

Drug prevention is a component of the drug control strategy. High school students, both inside and outside school, receive drug prevention education. However, this service has largely been confined to big cities, as mentioned in focus groups with drug users from smaller communities and rural areas. Another limitation of education messages rests in the country's limited literacy rate as well as the multiple languages in use in Myanmar.

International NGOs have had and continue to have a limited role in influencing drug policies in Myanmar and a limited scope of operation, imposed by the government. This is clear from the many reports that confirm that consultation of clients and NGOs has been and continues to be very limited. Even within their limited role, NGOs are generally considered more effective through their grassroots approach, programs and accessibility, in comparison to UN and government-operated activities. In effect, civil society in Myanmar is only marginally involved in drug policy, despite their role as the only agencies involved in providing care and support for drug users and people living with HIV.

Recommendations

The following are recommendations for the government of Myanmar based on focus groups of drug users and key informants:

1. Review the collaboration between drug demand, supply reduction, and harm reduction policies and activities across law enforcement and health sectors in Myanmar while incorporating and integrating expansion of free community-based drug treatment services based on international standards.
2. Urgently review, expand, and implement drug treatment policy and guidelines in line with human rights and evidence of effectiveness, especially in townships and villages where there is limited availability of such services.
3. Establish linkages between drug control policy and HIV policy toward a more humane approach to dealing with drug use and HIV.
4. Incorporate harm reduction interventions at all policy levels.
5. Expand prevention education and information on HIV and drug use to cover schools, in various local languages.
6. Establish services that meet the specific needs of female drug users.
7. Expand UN agencies' role in promoting a comprehensive range of services for drug users and their partners/families.
8. Urgently tackle the ongoing stigmatization and discrimination of people living with HIV and drug users, with a particular focus on female drug users.
9. Set up mechanisms to facilitate drug-user participation and engagement in order to contribute to the ongoing national responses to drug use and HIV.
10. Improve collaboration between law enforcement agencies and drug treatment services.

11 Urgently expand treatment to all regions.

12 Initiate comprehensive harm reduction services, including vocational training and health education in prison settings.

13 In light of the growing HIV epidemic, review and complement the legal provisions relating to drugs with HIV guidelines.

Thailand

In Thailand there has been no meaningful engagement of civil society in policy formulation or service provision for IDUs since 1998, the first point of reference for this report. Only when the human rights violations that accompanied the Thai government's "war on drugs" policy initiated in 2003—which included more than 2,000 arbitrary extrajudicial killings and the forced detention of thousands of suspected drug users in military boot camps—was civil society actively engaged with the authorities on issues of harm reduction and injection drug use. These early engagements, including formation of a National Working Group on Drug Use and HIV, and resulting in international support, allowed civil society groups to undertake small-scale service provision efforts. This included a grant from the Global Fund to Fight AIDS, Tuberculosis, and Malaria for harm reduction drop-in centers operated by the Thai Drug Users' Network (TDN). The Global Fund grant did not go through the traditional country coordinating mechanism, only further highlighting that the Thai government itself did not actively embrace a comprehensive strategy for preventing HIV among people who use drugs. Indeed, still today, outreach workers engaging with IDUs have no legal protection from government authorities to conduct their work.

The provision of needles and syringes to active injection drug users remains illegal and therefore conducting this work can bring unwanted interactions with police.

The provision of needles and syringes to active injection drug users remains illegal and therefore conducting this work can bring unwanted interactions with police. There is anecdotal evidence to show that without legal protection to assure that outreach workers and peer educators can deliver services to drug users, harassment and arrests of health workers can indeed occur.[439] Given the current policy environment that does not extend legal protection to health workers, it is difficult to foresee how services can be scaled up to reach optimal coverage levels or universal access targets among people who inject drugs in Thailand.

Rates of HIV prevalence among IDUs remain the highest among any community in the country, varying between 30 percent and 50 percent in the best available esti-

Chained drug users have a meal break at a Buddhist temple in Ayutthaya province, Thailand.
Reuters/Stringer Thailand

mates.[440] The Thai government continues to be lauded for its impressive achievement with its 100 Percent Condom Campaign launched in the early 1990s, which led to significant reductions in HIV transmission among sex workers and their clients even though sex work was criminalized and sex was a cultural taboo. Similar commitment and innovation is needed to address injection-related HIV transmission.

There have not been any concrete government commitments to reduce HIV transmission through injection drug use. In fact, drug users (both injectors and non injectors) continue to be overrepresented in the prison system,[441] which in Thailand (as elsewhere in the world) has been shown to significantly increase HIV transmission risk due to exposure to high-risk behaviors that include use of contaminated injection equipment, consensual and non-consensual sex, and tattooing.[442] However, in February 2008, figures from the International Centre for Prison Studies counted approximately 166,000 incarcerated individuals compared to a high of more than 250,000 in 2001.[443] But while the prison population has decreased, the proportion of people incarcerated for drug charges has remained consistently high.[444] In addition, there is no provision of needles or condoms in the penal system, but a few NGOs are doing advocacy and outreach work in prisons in Bangkok and Chiang Mai. A pilot condom project was operated in Bang Kwang prison in Bangkok in 2005 but distribution mechanisms were unclear. Sex remains illegal in prisons therefore limiting condom distribution. In most prisons, ART is provided. Only primary health care services are provided in all prisons.

Drug users (both injectors and non injectors) continue to be overrepresented in the prison system, which in Thailand (as elsewhere in the world) has been shown to significantly increase HIV transmission risk due to exposure to high-risk behaviors.

Furthermore, the National Rehabilitation Act of 2002 was designed to divert drug users from prison and into the treatment system. The Act noted that all people who use drugs were to be considered patients not criminals, but since the Act was passed, the "war on drugs" occurred and participants in focus group discussions mentioned that the "treatment" approach was used as a ruse to round-up drug users more readily and confine them to custodial settings.

During the war on drugs, blacklists were drawn up by law enforcement through coercion and blackmail of drug suspects and communities.[445] Today, when police arrest drug users, law enforcement agents have 45 days (pretrial detention) to present a case to the national rehabilitation committee, under the management of the probation department. At a case hearing, chaired by the hospital psychiatrist with support from the

probation department, the committee considers the case and delivers a verdict as to whether the accused should be incarcerated or sent to a treatment center.

There are currently 50 compulsory military boot camp-style drug treatment centers to which young methamphetamine users are sent if it is deemed they should not go to prison. Investigations into this system, however, reveal that it is deeply flawed, underfunded and is neither providing evidence-based drug treatment nor, in many cases, a diversion from prison since users awaiting trial or treatment are usually incarcerated in a prison setting, thereby negating the benefits of diversion. In addition, many users still end up in actual prisons.

To achieve a reduction in HIV prevalence among IDUs and to prevent a new epidemic among new injectors, the Thai government must significantly increase its engagement with civil society groups working on the issue, commit to a comprehensive national harm reduction implementation plan, and invest in evidence-based programs.

Today, estimates of the numbers of IDUs continue to indicate that there are fewer people injecting than 10 years ago, which should make it even easier to provide comprehensive services to people who inject drugs. While it is difficult to obtain accurate data on the number of injection drug users, a combination of older injectors dying from AIDS and the drug war has led to a significant drop in numbers, mostly because of shifts in use to other drugs such as alcohol and amphetamine-type stimulants.[446] It should not be forgotten though that HIV prevalence among injectors has remained high, at between 30 and 50 percent between 1989 and 2006[447] and there are now indications that a new wave of injection drug use is beginning to emerge, especially in areas close to heroin supply routes. To achieve a reduction in HIV prevalence among IDUs and to prevent a new epidemic among new injectors, the Thai government must significantly increase its engagement with civil society groups working on the issue, commit to a comprehensive national harm reduction implementation plan, and invest in evidence-based programs in order to provide the necessary supporting environment that people who use drugs require to access comprehensive services.

It would be remiss not to acknowledge some advances in the dialogue between government and civil society over the past ten years. Commitments and promises have been made in the last decade, including comments at the International AIDS Conference in Bangkok in 2004. Former Prime Minister Thaksin Shinawatra took the stage and announced that the Thai government would embrace harm reduction strategies, and would welcome international technical assistance to implement such strategies. Action

remains elusive in implementing any national harm reduction policy and, considering the past ten years and the apparent lack of progress on policy, it is difficult to know the government's plans for the future. The government's April 2008 decision to re-launch a version its drug war, though it has not reached the bloody level of 2003, signaled its willingness to accept collateral deaths as the price of drug control,[448] and the ease with which the government may discount previous commitments or switch directions in drug policy. Unless efforts are made to build the confidence of key stakeholders and involve them in a transparent and unified response to this epidemic, efforts to curb HIV transmission among people who use drugs and their sexual partners will remain bleak, as will the public health and human rights situation for people who inject drugs in Thailand.

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In 2006, an independent commission was formed, led by Kraisak Choonhavan, former senator and chairman of the Senate Foreign Affairs Committee, to investigate allegations of police abuse and extrajudicial killings during the 2003 war on drugs.[449] The report, completed in 2007, was censored and prevented from reaching the public eye. Highlights from the report have nonetheless been leaked and a regional news agency reports that:

> The committee found that about 1,370 of those deaths were related to drugs, while 878 were not. Another 571 people were killed for no apparent reason, according to the panel, and police investigated just 80 of those cases. To this day, the results of the report remain safely tucked away. The panel had no legal authority and could only make recommendations for prosecution. It determined that no senior Thaksin administration figures were linked to the killings, a finding that frustrated committee members who believed that conservative forces were trying to whitewash the deadly campaign.[450]

Key findings

IDUs in Thailand have traditionally suffered from the lack of comprehensive harm reduction services, high rates of HIV prevalence, and over-criminalization resulting in large

numbers of IDUs spending time in custodial settings. However, respondents noted that recent significant developments in regard to Thailand's drug policy, including developments toward a national harm reduction policy, appear to be having a positive impact. This is especially seen in terms of HIV prevention, given the recent awarding of a Global Fund application that has a significant harm reduction component. There have been a small number of government-initiated pilot programs providing medical services, including the provision of ART to IDUs, but the coverage is extremely limited. A recent report concluded that IDUs face greater discrimination in access to ART compared to the general population and other marginalized groups, despite the national ART program's open criteria.[451]

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Indeed, the Ministry of Public Health and the Office of the Narcotics Control Board are drafting a national harm reduction policy for IDUs but civil society groups are not consistently consulted or included in policy drafting phases. It is not clear when this will be ready or if in fact it will see consultation with civil society.

Despite the implementation of the National Rehabilitation Act of 2002, drug users continue to be over-represented in custodial settings. These are high-risk environments for the transmission of HIV and blood-borne viruses. In addition, the Department of Probation, in charge of treatment centers, informed investigators that the number of military-style compulsory drug treatment camps is rapidly increasing[452] and respondents showed concern about the lack of rigorous evaluation of their effectiveness. Such treatment centers are predominantly housed in military barracks and operated by military staff. What transpires inside these treatment centers is largely unknown but respondents reported military training with a focus on discipline and lectures on morality, toward social "re-education."

Reports from 2005 indicate that drug users are injecting a variety of substances, including midozalam (Dormicum). In particular, midozalam has been associated with unsafe injections and vein damage. There is currently no strategy to address this risk behavior and this issue has not been noted on the national agenda.

Meanwhile, civil society advocacy efforts have resulted in the inclusion of IDU service provision in recent Global Fund applications. It remains to be seen what role the Thai government will play as part of the initiation and expansion of services. At present, several civil society groups are providing services to IDUs, but their reach is dependent on precarious international donor funds. The Thai government's investment in services for IDUs

An activist protests the Thai government's war on drugs during a demonstration upon the arrival of UN Secretary General Kofi Annan in Bangkok in May 2006. STR/Stringer/AFP/Getty Images

and indeed HIV prevention in custodial settings has been at best limited, while the number of prisons and those incarcerated for drug offenses has continued to increase[453] and the system remains significantly overcrowded. The prison system can hold 80,000 people but has held as many as 240,000 in 2002 and now houses around 130,000 with many more in military camps.[454]

The continued efforts of UN agencies and civil society groups toward a comprehensive harm reduction strategy have led to the formation of the Thai Harm Reduction Network and the National Working Group on Drug Use and HIV. These positive initiatives are extremely tenuous due to major funding constraints; neither the government nor the UN contributes to funding them. In addition, the National Working Group has important limitations in reaching those key decision makers, as the Thai government's involvement has been restricted to parliamentarians and bureaucrats without support from high-level decision makers and ministers.

A significant communication gap between several key stakeholders from both government and NGOs was revealed through the interviews conducted for this assessment and consistently suggested that there was not enough dialogue and communication between various departments in the Ministry of Public Health and Office of the Narcotics Control Board and civil society groups. Over the past decade, interventions such as drug

treatment and HIV prevention among IDUs have thus largely been uncoordinated, underfunded and limited in scope.

There is a continued lack of hard data that realistically measures the extent of injection drug use in Thailand. This is often cited by government stakeholders as a reason that little investment is made in service availability.

Recommendations

The following recommendations should be enacted by the Thai government and UN agencies:

1. The National Working Group on Drug Use and HIV needs to be urgently reconvened and empowered. UN agencies need to help find financial support for this Working Group so that it can fulfill its mission to influence national program and policy decisions in matters relating to injection drug use and HIV. Key community stakeholders and strategic decision makers need to be recruited to enhance the committee's effectiveness.
2. The Thai government needs to further engage with civil society through community representatives who best understand the issues of injection drug use and HIV. Civil society's efforts indeed can complement and enhance those of the government if action is coordinated, transparent, and founded on common goals. This particularly applies to the drafting process of a National Strategic Plan for Harm Reduction.
3. Despite policy changes, like the National Rehabilitation Act, that have acknowledged the need for drug treatment and clearly mention that people who use drugs should be treated as clients, too many drug users spend time in the criminal justice system or compulsory drug treatment centers. People diverted to treatment spend a minimum of four months in correctional settings. The centers are military barracks converted into military-style drug rehabilitation implemented by the military. A rigorous review of the National Rehabilitation Act and its implementation has just been conducted, though its results remain unpublished. An open, transparent and participatory evaluation should be initiated by the Thai government. In addition, a scientific evaluation of drug treatment services is required in order to quantitatively and qualitatively evaluate their results. The increasing number of compulsory centers that the government wants to open as noted by the director general of the Department of Probation, should be immediately halted until a well-designed evaluation assessing the effectiveness of these centers is undertaken.
4. The Thai government should formulate a harm reduction policy that recognizes changing drug trends where increasing numbers of people are injecting Dormicum[455] and smoking methamphetamine tablets. Harm reduction policy and practice must recognize the implications of these trends on HIV risk behavior, especially the need for clean injecting equipment in the case of Dormicum and improved

availability of sexually transmitted infection diagnosis and treatment for methamphetamine users.

5 The various departments and ministries responsible for drug use, public health, public security and HIV prevention, care, and treatment need to improve coordination and harmonize their agendas toward a common national strategic plan and jointly support a comprehensive approach to the intersection of these issues. This should culminate in an enabling environment where services to people who use drugs can more easily be accessed and scaled up, intimidation and threats of incarceration and abuse are diminished and eliminated, and where people who use drugs can be involved meaningfully in all levels of decisions relating to their own wellbeing through a balanced approach to public security and public health.

6 There is an urgent need to support drug use epidemiology research networks in Thailand. The UN and other international agencies should support the technical research capacity of the already-established Thai Academic Substance Abuse Network. This would allow for ongoing monitoring of injection drug use and for better public health responses. In addition, the Academic Substance Abuse Network should be utilized to conduct a rigorous evaluation of the effectiveness of compulsory drug treatment centers. Furthermore, ongoing evaluation of methadone programs and other opiate substitution programs will improve the delivery of drug treatment services for those people who voluntarily seek them. Similarly, Thai civil society groups should also improve their monitoring and evaluation systems.

Vietnam

Fundamental shifts in HIV and drug control policies have occurred in Vietnam over the past ten years. Indeed, a decade ago, there were virtually no policy provisions to address HIV and injection drug use, while today explicit policies support HIV prevention among IDUs through a national HIV/AIDS strategy and through drug control legislation.

Indeed, the HIV/AIDS Law of June 2006, the first piece of legislation approving harm reduction interventions, specifically mentions "the promotion of the use of condoms and clean needles and syringes, treatment of opioid addiction by substitution, and other harm reduction measures to support safe behaviors to prevent HIV infection and transmission" (Article 2, Clause 15). Additional harm reduction interventions—expansion of needle and syringe distribution/exchange and pilot methadone maintenance therapy, and peer education—have been implemented as a result of the enabling environment created by the HIV/AIDS Law.

According to the government, by the end of 2007, up to 43 percent of IDUs in project areas in 33 provinces with higher HIV prevalence had been reached with any kind of health services. More than ten needles were distributed per IDU through peer educators

over a period of one month in 2007, an increase from 2.6 needles per month in 2006.[456] Methadone treatment began in 2008 with six clinics in two provinces, aiming to treat 1,500 drug users by the year's end. The National Action Plan on Harm Reduction Interventions in HIV Prevention in the 2006-2010 Period aims to increase the use of clean needles and syringes to 90 percent among IDUs, expand harm reduction interventions in all 64 provinces, and provide methadone treatment in 10 provinces.

Furthermore, the 2008 amendment[457] to the national drug control legislation contributed to the growing acknowledgement that people who use drugs require effective prevention, treatment, care, and support services. The amendment, despite the general prohibitive principles, endorses harm reduction (Article 34a), permits voluntary community-based treatment as well as post-rehabilitation supervision, and stipulates a post-rehabilitation period ranging from one to two years. Combined, the provisions enshrined in the HIV/AIDS Law and the 2008 drug control amendment have created the conditions for local law enforcement to actively support syringe exchange programs and methadone treatment services.

During the same period, legal punishment for drug convictions has been relaxed, with a greater focus on drug treatment—as understood by policymakers. Drug users reported in focus group discussions that people who are caught using drugs and convicted of drug possession or trafficking are sent to a drug treatment center instead of prison. Before 2000, if two or more people were caught using drugs together, they were convicted of "organizing drug use," resulting in a conviction of nine years, leading to an average of seven years of imprisonment. After 2000, the same conviction, reformulated as "possession and use of drugs" led to a conviction of one to seven years with an average term of three years served, according to respondents. Registered drug users who relapse are recently being diverted to drug treatment centers instead of earning the traditional two-year prison term previously enforced. It is expected that with the amendment, more drug users will be sent to access treatment communities.

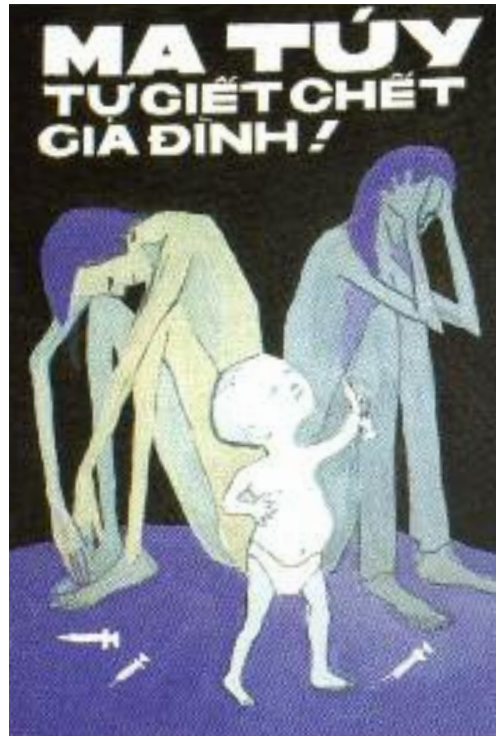
In 1996, Vietnam had an estimated total prison population size, including pretrial detainees, of 43,000, with a prison population rate of 56 per 100,000.[458] By 2006, the total national prison population is estimated to have more than doubled to 98,556 and a growing incarceration rate of 116 per 100,000.[459] However, drug users note that recently, recourse to incarceration is tempered by availability of drug treatment, focusing on mandatory institutionalized rehabilitation.

According to drug users interviewed, detoxification is the only treatment available and delivery varies between centers. Some provide "cold turkey" treatment where drug users are locked in a so-called clinic for ten days to two weeks. Other centers provide some pain relief medication but the approach is far from patient-centered and usually does not meet client needs.

The number of mandatory drug rehabilitation centers has been increasing for several years. At present, 109 rehabilitation centers are operating across Vietnam, a significant increase from the 80 centers in 2006.[460] In the centers, drug users are made to work long hours and have no privacy or leisure time. In focus group discussions, former drug users reported that they were made to do different kinds of tasks—from cracking cashew nuts and painting decorative animals to making bricks. Skilled drug users were assigned skilled tasks—such as welding—while others carry materials and products.

Participants of the focus group discussions also reported being subjected to physical punishments. They said that physical abuse by treatment center staff is frequent and is imposed on clients for breaking the rules. Participants reported being physically punished by staff for fighting among clients, selling tobacco, carrying money, and using drugs.

The average stay in such centers has also been increasing steadily—from three months several years ago, to two years today. Even more recently, special decrees came into effect in seven locations across the country that facilitate an extension to the two-year stay by an additional two to three years.[461]



A billboard in Vietnam reads "Drugs kill your family." Such antidrug propaganda perpetuates stigma and discrimination of drug users. Courtesy of Peter Higgs (Reproduced from UNODC publication: "An album of drug prevention posters" published in Hanoi, 2001.)

Interviews with key informants reveal that HIV testing in drug treatment centers is still an issue of great concern despite some improvements. Two centers in Ho Chi Minh City have voluntary counseling and testing services but in most other centers, voluntary counseling and testing is not available. Testing is done in some centers without counseling, and without informing clients of the test results. In some other centers, testing is fee-based.

In addition, according to interviewed drug users and leaders of groups of people living with HIV, ART has been made available in a few centers but in most, drug users depend on their families to bring in a supply of medication.

In almost all interviews and discussions, drug treatment centers were raised as an important challenge that led to much frustration, often described as "incubators for HIV and human right abuse."

Key findings

Most governmental agencies and civil society or "mass organizations" support punishment and mandatory rehabilitation for drug users, despite the lack of evidence to support the projected outcomes. Indeed, drug treatment centers remain a form of punishment; people who test positive for drug use are forced into the centers. In many cases, voluntary admissions (prescribed for three to six months) resulted in an extended stay comparable to those under legal remit. From 2003 to 2008, in Ho Chi Minh City, drug users in focus group discussions reported that those who enter a treatment center following a contract of voluntary treatment for six months ended up being kept for two years of rehabilitation and two-to-three years post-rehabilitation.

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In the majority of drug treatment centers, drug users become cheap labor where residents work long hours comparable to three times the shift of a manual worker outside the centers, with physical punishment if quotas are missed. A symbolic income is provided—a fraction of the salary for comparable work outside the center—for conversion into vouchers valid only at the center's canteen where items on sale fetch outrageous prices. Interviews revealed that between 2007 and 2008, drug users in a Hanoi center were forced to paint 2,500 decorative statuettes every day to earn 350,000 Vietnamese Dong (VND) per month (about $20 USD), paid as canteen vouchers. Meanwhile, manual laborers outsidethe center can earn 1,200,000 per month for painting a quota of 800 statuettes a day.

Drug treatment centers are generally stringently regimented where residents wake, eat, work, wash, and sleep at fixed hours. The time allowed for eating, washing, and resting is reduced significantly for clients who have not met the work quotas. Recreation spaces are practically nonexistent. With little or no privacy, residents found consuming alcohol or tobacco are subjected to severe punishments. In some cases, drug users in Hanoi reported

that even drinking tea was prohibited. Former female clients in the focus group discussion noted that they were given lighter workloads and were given more washing powder compared to male residents. Pregnant women were usually sent back to the community.

Many former treatment center clients who participated in the focus group discussion reported punishments in the centers with horror, all involving physical restraints. In one center in Hanoi, both male and female residents were locked in a windowless one-meter-square cell for up to a week with two sparse meals each day and no access to showers or sunlight. In Ho Chi Minh City, punished residents were hung by their arms for a week. Several respondents said they felt inferior to animals after serving such sentences.

Drug treatment center clients described the following four main vectors for HIV transmission in the centers:

In one center in Hanoi, both male and female residents were locked in a windowless one-meter-square cell for up to a week with two sparse meals each day and no access to showers or sunlight.

- Sharing injection equipment: since needles are not available and drugs continue to be smuggled in, sharing drugs and injection equipment is common. One needle may be shared with up to ten people if not more, even among drug users who are known to be living with HIV.
- Sharing tattooing equipment: many male and female clients have tattoos made even though tattooing is prohibited. Sharp objects such as homemade needles, as well as ink for tattooing are often shared. Because it is prohibited, tattooing often takes place in hiding and in unhygienic conditions.
- Sharing sharp objects for penile implants: increasingly common among men, implants thought to increase the pleasure of sexual partners are being inserted in the shaft of the penis with sharp objects. Some respondents have even reported the exchange of implanted objects.
- Sexual transmission: male-to-male and female-to-female sex is common in most centers. According to respondents, promiscuity among men is a significant risk for HIV transmission where young drug users who "have fair complexions and look clean" often become shared partners of "big brothers." Since condoms are not provided, an official from the local Social Evil Control Department mentioned that measures are being implemented to prevent sex between men from occurring by having all residents bathe together and leaving the lights on during night hours.

In contrast to drug treatment centers, harm reduction interventions are currently being implemented in community settings with health authorities providing special passes to operate needle and syringe exchange programs unhindered and ensure that peer educators are not arrested while distributing needles and syringes to drug users. Although incidents of arrests for distributing needles still occur occasionally, the frequency of such occurrences has decreased significantly in recent times according to respondents. In early 2008, methadone treatment was initiated with the objective of reaching 1,500 clients in two cities most affected by drugs, and reaching another 1,500 in Hanoi in 2009.

Through the implementation of harm reduction, people affected by drugs have become involved in the national HIV/AIDS response. A considerable number of people who are using and recovering from drug dependence now distribute needles and syringes and work for NGOs through a push to reach the sexual partners of drug users who are also at risk of HIV infection. However, there is still no drug user organization or group that is dedicated to protecting their rights and wellbeing.

Where ART is not readily available due to lack of funding, drug users are disproportionately underrepresented and service providers reportedly use relapse as a justification for discontinuing treatment.

Increasing numbers of drug users living with HIV now have access to ART after the government changed enrollment guidelines wherein drug abstinence is no longer a criterion. This happened as a result of long-term advocacy efforts by different stakeholders, including international organizations and networks of people living with HIV. In 2006 a protocol for antiretroviral treatment was issued by the Ministry of Health, in which drug use was removed from the exclusion criteria. Also, with PEPFAR involvement, more antiretroviral drugs are available than ever before. The PEFPAR team was also involved in advocacy for treatment for drug users living with HIV.

However, in so-called "non-project provinces" where ART is not readily available due to lack of funding, drug users are disproportionately underrepresented and service providers reportedly use relapse as a justification for discontinuing treatment.

Most drug treatment center clients are tested for HIV without counseling or being informed of the test results. Out of more than 100 centers, only a few provide ART. Drug users who were already accessing ART before entering the center and those who have developed AIDS are informed of their status and can access treatment. However, the majority of centers do not provide ART or treatment for opportunistic infections. Former residents report that bribes are often necessary to initiate and even continue ART.

A billboard in Vietnam encourages society to crush "drugs" and "sex," stating that "preventing harmful and poisonous culture is the responsibility of the whole society." Courtesy of Institute for Social Development Studies

Similarly, people living with HIV suffering from opportunistic infections have to pay or bribe officials to access treatment for those infections. Without such bribes, treatment is often limited to centers' poorly staffed and ill equipped clinics. When clients' health becomes critical, they are transferred to respite homes or local hospitals. In cases of poor prognosis, families are called to bring them home to die—outside the center and the hospital.

INVOLVEMENT OF CIVIL SOCIETY IN DRUG POLICY

There is little involvement of civil society in drug policy. Very few respondents were aware of the content of the national drug control policy and similarly, knowledge about drug treatment was very limited. Drug users were aware of legal provisions that directly affected them such as different drug-related convictions under the Criminal Code and Drug Control Law, but were not involved in policy decisions in any way. Only one Vietnamese NGO, Institute for Social Development Studies, proactively advocates for harm reduction and more humane approaches in drug treatment. However, civil society has never been formally invited to take part in the development of drug control policies.

Participants had mixed feelings about the impact of drug policy in regard to supply and demand reduction. Law enforcement agencies report quantitative data that suggest that drug use and trafficking are on the rise, yet many drug users and service providers reported a decrease in new users and less drug consumption. Still others noted the presence of a greater range of types of drugs and increasing numbers of women using drugs.

Recommendations

The government of Vietnam should enact the following recommendations:

1. Implement evidence-based campaigns to raise awareness about drugs and acknowledge the physiological aspects of drug dependence.
2. Integrate harm reduction into mainstream drug treatment and HIV prevention programs in order to provide the most comprehensive and effective care and treatment for people living with HIV and ensure respect for human rights.
3. Develop and enforce concrete guidelines to refer drug users to treatment centers and other treatment options, and to ensure that those treatment options are in line with international norms and standards.
4. Rapidly scale up methadone treatment and continue the expansion of syringe exchange programs as well as outreach activities.
5. Support the development of drug user organizations and those that support them.
6. Develop mechanisms to involve civil society, including drug users, in the design and implementation of policies that affect drug users.

Notes

434 AHRN would like to underline the special contributions of people who use drugs in Myanmar, Thailand and Vietnam who provided the necessary information to prepare this report. AHRN would also like to thank Ms. Khuat Thi Hai Oanh, Mr. Nick Thomson (JHU), and the consultant in Myanmar for their support in conducting data collection and a primary analysis of the data. AHRN also acknowledges the work of Khun Baralee Meesukh in coordinating the logistics and overall project arrangements. Finally, AHRN would like to congratulate Mr. Pascal Tanguay and Mr. Gerard de Kort as the main authors and for successfully completing this report.

435 The data presented here is not official data as it has not been published. However, this data is often referred to in meeting and workshops. Unfortunately, neither the data sources nor the workshop reports are published.

436 Phase 1: 1999-2004; phase 2: 2004-2009; phase 3: 2009-2014.

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438 The locations of the six DTCs that offer methadone are: Yangon, Mandalay, Lashio, Mythkyina, Moegaung, and Bamo.

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444 UNODC. (2006) op. cit.

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446 Vongchak, T., Kawichai, S., Sherman, S., Celentano, D.D., Sirisanthana, T., Latkin, C., et al. (2005) The influence of Thailand's 2003 war on drugs policy on self-reported drug use among injection drug users in Chiang Mai Thailand. *International Journal of Drug Policy, 16,* 115-121.

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449 "War on Drugs Returns to Bite Thaksin," (November 24, 2006) *Bangkok Post*.

450 "Thailand to Restart War on Drugs" (March 4, 2008) *Asia Sentinel*. Available online at http://www.asiasentinel.com/index.php?option=com_content&task=view&id=1079&Itemid=185.

451 Human Rights Watch. (2007) op. cit.

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Pakistani Interior Minister Faisal Salah Hayat talks to the press as seized drugs burn during a ceremony in Quetta. More than 50 tons of drugs and alcohol were destroyed that day. Banaras Khan/AFP/Getty Images

Twin Epidemics—Drug Use and HIV/AIDS in Pakistan

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Introduction

Pakistan is at the forefront of global efforts to reduce supply and demand of illicit drugs. This study documents some of the key health and human rights consequences of national efforts to comply with international drug control agreements, particularly as they apply to injection drug use and HIV. Data were collected from both primary and secondary sources. Primary data came from open-ended interviews and personal communications with injection drug users and service providers in Karachi, Pakistan. Secondary sources reviewed for the report included national and international reports and studies on patterns of illicit drugs and the HIV/AIDS epidemic.

With a population of 164.74 million,[463] Pakistan is home to one of the world's largest populations of opiate users.[464] It is a key transit and supplier country of narcotics, particularly opium and heroin. Pakistan borders Afghanistan, the world's largest opium producer, and has its own history of opium production dating back to British colonial times. However, as a signatory of various conventions related to supply and demand reduction of opium and heroin, Pakistan achieved poppy-free status in 2000-01, down from peak level of 9,441 hectares (ha) in 1992.[465]

Consequently, over the last ten to 15 years, there has been a shift from the traditional inhaling and smoking of heroin to injecting heroin and synthetic drugs. The proportion of injectors among all heroin users has increased significantly over the past 15 years, from 1.85 percent in 1993 to more than 15 percent in 2000[466] and 26 percent in 2007.[467] Simultaneously, Pakistan experienced an increase in HIV transmission, and the emergence of a concentrated epidemic among IDUs. In some urban areas, the HIV prevalence rate among IDUs has reached 51 percent.[468]

Currently, there are five million drug users in Pakistan.[469] According to the last National Drug Assessment Study of Pakistan (2006-2007), the number of opiate users is 628,000, out of which 77 percent (484,000) are chronic heroin users, with a substantial number of users shifting from inhalation to injection. The estimated number of injection drug users is 125,000.[470] The epidemic is further aggravated among IDUs by severe forms of discrimination, stigmatization, and marginalization.

National attempts to reduce the supply and demand of illicit drugs

Pakistan is a signatory to the three UN Conventions of 1961, 1971, and 1988 on the control of narcotics and psychotropic substances, and party to the General Assembly's 20th Special Session on Drugs. Pakistan has also signed numerous regionally based drug control agreements including the South Asian Association of Regional Countries (SAARC) Convention on Narcotic Drugs and Psychotropic Substances, and the Economic Co-operation Organization (ECO) Protocol on Drug Matters. In addition, Pakistan has agreements with Afghanistan and Iran, major producer and transit countries, to strengthen border security and control the drug trafficking flow.

The act grants death penalty for possession of more than 100g of heroin or 200g of opium. As of November 2008, 88 people had been sentenced to death.

In response to the international and regional agreements, Pakistan has taken aggressive legislative and programmatic measures, particularly during the last 10-15 years, with the technical and financial support of United Nations and other donor agencies.

In 1997, the government of Pakistan enacted two anti-drugs laws: the Control of Narcotics Substance Act (CNS Act 1997), and the Anti Narcotics Force Act (ANF Act 1997). The CNS Act 1997 regulates prohibitions of narcotic drugs' import, export, trafficking, and manufacture, and prescribes punishment for contraventions.[471] The act encompasses all provisions of previous related laws in addition to new provisions of harsh punishments for drug-related charges. For the first time in the history of Pakistan, capital punishment for trafficking and financing of narcotic drugs was introduced under the CNS Act 1997. The act grants death penalty for possession of more than 100 g of heroin or 200g of opium.[472] The proscribed quantity for opium is much smaller as compared to other countries in the region; for example, 500g in Sri Lanka, 2 kilograms (kg) in Bangladesh, or 10kg in India.[473] As of November 2008, 88 people had been sentenced to death.[474]

The ANF Act 1997 sets out the constitution, functions, and powers of the Anti Narcotics Force.[475] One of the important steps under this act was the establishment of five Special Narcotics Courts in 2000 to speed up drug investigations and prosecutions in Peshawar, Lahore, Karachi, Islamabad, and Quetta. Soon after the establishment, 1,050 ANF cases pending in various courts of law were transferred to these newly established courts. Within less than one year, these courts prosecuted 400 cases, with a 92 percent conviction rate among which 32 defendants received the death penalty.[476]

In addition, under the ANF Act 1997 and NCS Act 1997, for the first time, law enforcement agencies' jurisdiction extended to the tribal belt of the country,[477] an area of extensive poppy cultivation and the conduit for the drug trade/trafficking via Afghanistan.

While the ANF is the primary law enforcement and coordinating agency, multiple agencies in Pakistan have been empowered to enter premises, search, seize, and arrest people without a warrant, in order to control the illicit drug trade. These agencies include the Provincial Excise and Police Departments, Customs Department, Frontier Corps, Airport Security Force, the Federal Investigation Agency, and the Pakistan Coast Guard, all of which work closely working with ANF.[478]

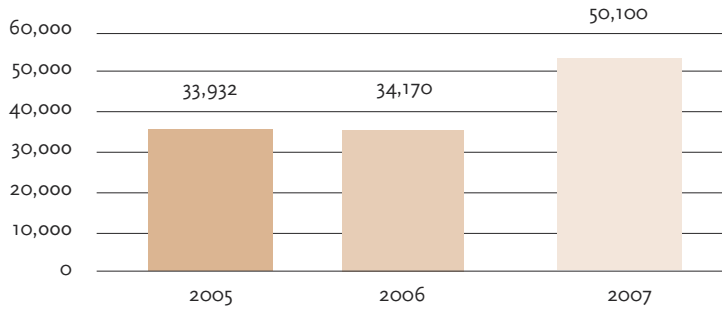
Since 1998, Pakistan has adopted a "no tolerance for cultivation" policy against poppy growers. With the assistance of UNODC and a budget of 56 million USD, in 1999 the government implemented a Five Year Master Plan for Drug Abuse Control. One of the objectives of the Master Plan was to control the supply and production of narcotic substances within the country through eradicating the entire opium poppy crop by the year 2000, and eliminating all heroin-producing laboratories.[479] The UNODC playing a pivotal role in policy formulation, operational capacity building of law enforcement agencies, and promoting sub-regional cooperation to enhance the efforts against drug trafficking.[480]

With this ambitious plan, Pakistan achieved a poppy-free status in 2001 and became a "success story" in the global war on illicit drugs. The domestic cultivation decreased to nearly zero, falling to 213 (ha) in 2001 from 9,441ha in 1992.[481] The same year, Afghanistan also experienced a sudden and substantial decline in production of opium due to the Taliban's ban on cultivation. In addition, Pakistan repeatedly seized substantial quantities of opium and heroin: Pakistan's law enforcement agencies seized some 8,755kg of heroin in 2001.[482] Because of the dramatic decrease of opium production in Afghanistan, the prices of opium and heroin increased sharply in global markets, and particularly in Pakistan and Iran. In Pakistan, the average wholesale price of opium was 2,392 USD per kg in the year 2001, up from 1,709 USD in 2000.[483]

In 2003, there was a reemergence of poppy cultivation in many parts of the Pakistan due to increased price of opium and heroin.[484] However, in subsequent years, official reports indicate a decline in domestic production and control over trafficking from Afghanistan. The Economic Cooperation Organization Drug Control Coordination Unit estimates that demand for heroin in Pakistan is somewhere between 60 to 80 tons.[485]

Along with control of domestic production and trafficking of opium, the law enforcement agencies began destroying opiate conversion laboratories. By the late 1990s, most opiate conversion laboratories had shifted to Afghanistan, presumably as a measure to protect them from the law-enforcement actions in Pakistan, as well as to be closer to the raw opium in Afghanistan.[486] There has been an increasing number of arrests on drug-related charges, as Chart D illustrates.

Chart D. Number of persons arrested on drug charges



Data source: International Narcotics Control Strategy Report 2008, U.S. Department of State

Health and Human Rights Consequences

Sharp growth in number of IDUs

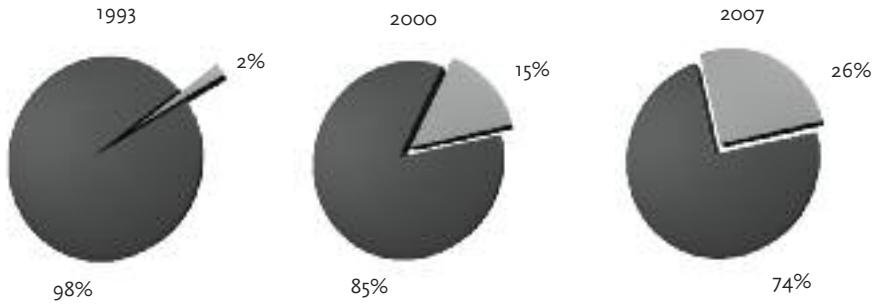
In Pakistan, the use of heroin and pharmaceutical drugs through injection was not a common or preferred method of use until the late 1990s. In 1979, there were 80,000-100,000 opium users and the number of heroin users was virtually unknown.[487] Thirteen years later, the National Survey on Drug Abuse (1993) estimated that there were 2.7 million drug users in Pakistan, 1.52 million of which were heroin users. The same survey also noted that in Karachi, a major urban center, 1.8 percent of "addicts" injected drugs.[488]

Subsequent national studies have indicated a sharp increase in the number of injection drug users. At present, Pakistan has one of the highest prevalence rates of injection drug use in the world.[489] According to the estimates of Pakistan's National Drug Assessment Study of 2000,[490] out of 500,000 chronic heroin users, 15 percent administered their drugs through injection. In contrast, the national study of 2006-07 presented a relatively comparable numbers of heroin—484,000—but the number of injection drug users jumped to 125,000 (26 percent), representing a 40 percent increase in the estimated figure for 2000.[491] [see Chart E]

However, the actual number of IDUs could be much greater than the data reflect; as one service provider commented: "The government's figures are a small chunk of the total IDU population. The actual number of IDUs is far greater at between 4 to 5 million, including women. Most of the IDUs are mobile and live on the streets so it is very difficult to get a hold of even half of the population. The number of IDUs is growing exponentially because of easy access to pharmaceutical drugs." (Male service provider, Karachi Pakistan).

Increases in heroin prices since 2001 have been accompanied by increased injecting of synthetic drugs that are cheaper and accessible without a prescription. Several studies of drug users in Pakistan have indicated that a transition from inhaling to injecting heroin

Chart E. Increase in percentage of injectors among all heroin users



and synthetic drugs is closely associated with the price, availability, and quality of heroin and synthetic drugs.[492]

One 36-year-old injection drug user explained his reasons for switching from inhaling to injecting drugs as follows:

> The main reason is the price of heroin. A few years back, I hardly spent 20-30 Pak rupees daily and easily got it from a nearby dealer. Now, I have to travel for more than an hour from Buns Road to Sohrab Goth to get the heroin and it costs 200-300 rupees depending on the quality of heroin. I am also jobless for the last three years, begging on the street to satisfy my addiction. Once or twice a week, I inject heroin but the rest of the time I am injecting Avil or capsule [Diazepam] with water. (36-year-old male IDU, Karachi, Pakistan)

At present, the most common pharmaceutical drugs used are benzodiazepines and antihistamines (Avil, Diazepam, and Marzine), often used in a cocktail. Most pharmaceuticals are dissolved in (often non-sterile) water before use.

Most injection drug users prefer to inject drugs in groups in shooting galleries." The main reasons users cited for group injecting are to minimize the cost, for companionship, and to provide protection from the police. As an interviewee mentioned:

> Most of the time we inject drugs in a group to minimize the cost. Three or four of us [users] collect money and buy the white stuff [heroin]. Then we equally divide it i.e. one cc each. (32-year-old Male IDU, Karachi, Pakistan)

In other settings, use of shooting galleries is shown to increase the odds of needle sharing,[493] and is associated with heightened risk of HIV infection.[494]

Drugs are commonly injected in the back of the hand, or in the legs and arms. Abscesses and skin infections are common problems.

Pharmaceutical cocktails often contain impurities that can cause abscesses and vein damage when injected. Courtesy of Gul Shamim

IDUs and HIV/AIDS

Over the last ten years, with the sharp increase in the number of injection drug users, Pakistan has also experienced subsequent HIV outbreaks among this segment of the population. The HIV/AIDS epidemic in Pakistan is concentrated among IDUs and in certain urban areas prevalence among this group has reached 51 percent.[495] [see Chart F above]

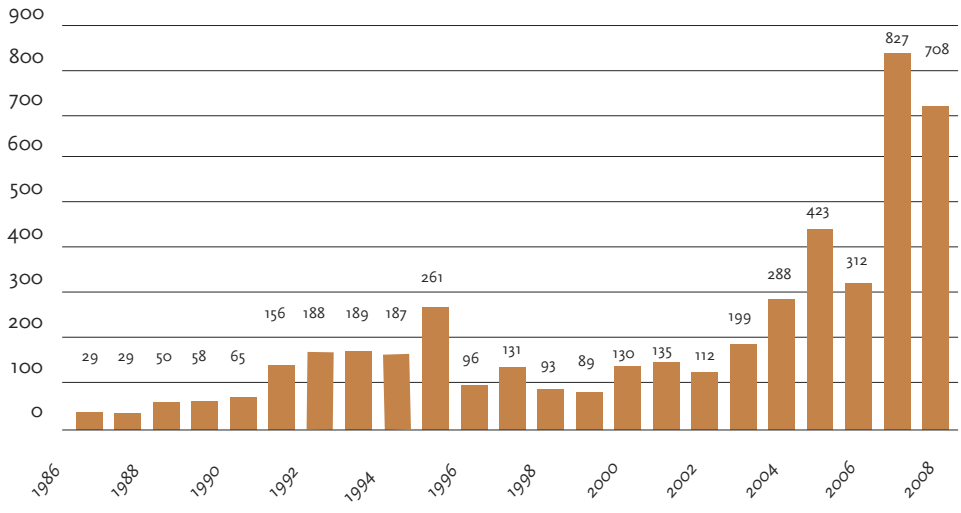
The first HIV case in Pakistan was reported in 1986.[496] During the initial years, the rate of transmission was low, and Pakistan was not considered a high-prevalence country. In contrast, the last seven years are characterized by sharp upward trends in reported cases and HIV prevalence among IDUs.[497]

The first major outbreak of HIV among IDUs was reported in 2003 in the city of Larkana, Sindh Province. Out of 175 IDUs tested, 10 percent of them were positive for HIV.[498] According to Pakistan's National AIDS Control Program report, the HIV prevalence among IDUs in Karachi, Sindh, rose steeply from 0.4 percent in January 2003 to 26 percent in 2005.[499]

National HIV/AIDS Surveillance data indicates that the overall prevalence rate in 2005 was 10.8 percent and rose drastically to nearly 21 percent in 2008. HIV prevalence among IDUs is more than ten times higher than reported prevalence in other groups: The prevalence among male sex workers is 1.5-1.8 percent, and the prevalence in general population is less than one percent.[500]

With the increasing rates, the epidemic has established a foothold throughout the country. The National Surveillance Study Round III (2008) has found HIV prevalence rates over five percent among IDUs in all eight cities surveyed in all four provinces. This is in comparison to a prevalence rate greater than five percent in five out of eight cities in

Chart F. Increase in reported HIV/AIDS cases, Pakistan



2005.[501] Half of the 125,000 injection drug users are married and an estimated 60,000 wives and 240,000 children are at risk of HIV transmission.[502]

According to the Pakistan National AIDS Control Program, 4,755 HIV cases have been reported as of September 2008. IDUs account for the largest proportion of cases at 33 percent (1,577 cases).[503]

However, reported cases do not capture actual HIV infections in Pakistan, as people are afraid to report due to the stigma attached to being HIV positive, and also lack of awareness and HIV testing services. According to UNAIDS estimates, the number of HIV/AIDS cases are between 46,000 and 210,000 in the country.[504]

The epidemic in Pakistan is following a trajectory similar to that of neighboring Asian countries—a higher incidence of HIV/AIDS among injection drug users, which is then transmitted to others through sex, including commercial sex, and paid blood donation.[505] The results of the national HIV/AIDS Surveillance Round II reveal that 86% of the 33,000 IDUs surveyed were sexually active and 46 percent reported sex with regular female partners. In that group, 16.5 percent reported condom use during their last sexual contact. Slightly more than a quarter (27 percent) reported paying for sex with a female sex worker during the last six months and, among these, only 21 percent reported using a condom.[506]

With the increasing number of IDUs and related HIV transmission, both government and civil society organizations have scaled up basic services, which include needle and syringe exchange programs, counseling, HIV testing, and detoxification. However, with the increasing number of IDUs and shortage of resources, coverage is still limited. Only 16 percent of IDUs have access to government-provided services.[507] Expressing frus-

tration with the lack of funding, a service provider working at a treatment and rehabilitation center said:

> Due to the shortage of resources and the escalating numbers of IDUs it is very difficult to provide even basic services, i.e. syringes and space for a shower, at drop-in centers. (Male, coordinator for last six years at drop-in center, Karachi, Pakistan)

Many injection drug users, themselves, express a desire for treatment, but low coverage and lack of access to services are major barriers.

> I want to start a new life and get rid of this addiction but there is no way that I can move on. I went to the treatment and rehabilitation center twice, but they just note down my name and ask me to wait for a few months. (43-year-old male IDU, Karachi, Pakistan)

We have now become a very easy source of income for the police. If we do not have money then they will arrest and put us in the jail...quite often, they will beat us without any reason. They assume that we are intoxicated and do not feel the pain.

In addition to lack of preventive services, there is no viable after-care system following treatment, leaving users with little support in relapse prevention.

> I received treatment from the center to get rid of this illness. After four months of treatment, I chose this door again because of lack of moral and financial support for my survival, in addition to insolent treatment from immediate family members. They were afraid and kept me in a separate room so they would not get any of my infections. Now that I am not with them there is no tension and also no hope for a normal life. (32-year-old male IDU, Karachi, Pakistan)

Barriers to Access Prevention and Treatment Services

With the alarming rates of HIV transmission, IDUs also face criminalization, forced testing, and discrimination and stigmatization.

Criminalization: Under the criminal justice system of Pakistan, possession of illicit drugs is illegal and punishable. The International Narcotics Control Strategy Report (2008) published by the U.S. Department of State claims that the "the Government of Pakistan views addicts as victims, not criminals," but the reality is different. Police behavior has been harsh toward people who use drugs.[508] Arrest, detention, and imprisonment of drug users, particularly injection drug users, are very common. People who

A policeman stands in front of a pile of burning drugs on the outskirts of Peshawar. Tariq Mahmood/AFP/Getty Images

use drugs often have to pay money to law enforcement authorities to protect themselves from arrest and detention.

As one drug user said:

> To keep ourselves away from the watchdogs [police] we have to shift our location frequently. They are in search of us to get money most of the time. We have now become a very easy source of income for the police. If we do not have money then they will arrest and put us in the jail...quite often, they will beat us without any reason. They assume that we are intoxicated and do not feel the pain. Sometimes they even ask [us] to take off our clothes and they hit [us] on our injection wounds, which is very painful. (41-year-old male IDU, Karachi, Pakistan)

Involuntary HIV testing: Both the national and international laws prohibit forced HIV testing for any individual. However, in Pakistan, authorities often forcefully send injection drug users for testing. During the fieldwork for this study, 13 interviewees said that their HIV status was positive. Nine of these said that the tests were conducted without their consent. As mentioned by one of the street drug users:

> I would never have allowed them if I knew before the test that it was for HIV. A year ago, I went to the drug rehabilitation center due to a high fever and

> they referred me to the civil hospital. There were some tests and the doctor gave me four tablets and asked me to buy some other medicines from the pharmacy, which I didn't buy because I did not have the money to buy them. A few months later, the service provider at the rehabilitation center informed me that I am HIV positive. After that they never offered me any kind of treatment except free syringes. (37-year-old male IDU, Karachi, Pakistan)

There have been several instances of large-scale forced testing in the past. Following a major HIV outbreak among IDUs in 2003, IDUs were forcibly tested for HIV.

According to the Pakistan National AIDS Consortium:

> On June 15th 2003 the Larkana jail authorities referred an inmate, who was jailed on charges of illegal drug use, for HIV testing to the Sindh AIDS Control Program (SACP), Larkana. The inmate tested positive for HIV and the jail authorities reacted in alarm. Eighty jail inmates arrested on drug charges were tested for HIV involuntarily. The jail authorities also began arresting people using drugs on the streets for mandatory testing. A total of 145 drug users were screened without consent, out of which 65 were arrested from the streets. To make matters worse, the local newspapers and local TV channel began to interview the HIV- positive persons without consent. The HIV-positive persons who were now openly identified became a target for stigma and discrimination. As a result, drug users on the streets were driven underground from fear of being jailed and tested.[509]

Media reports stated that, "the fear of the police, forced testing, and media harassment led the injecting drug users, and HIV infected persons to flee the city and spread all over the province and the country."[510]

Such behavior from law enforcement authorities inhibits the access of people who inject drugs to available prevention services; due to fear of arrest and forced testing, they remain isolated and transient.

Discrimination and Stigmatization: Generally, in Pakistan, injection drug use is considered a social evil and HIV/AIDS is seen as a punishment for those who act against the defined moral values. Islam, the state religion of Pakistan, prohibits sexual intercourse outside of marriage, adultery, homosexuality, and the use of intoxicants.[511] There is general perception that AIDS is a divine punishment for anyone who indulges in such behaviors. IDUs who have no private residence in which to inject are subject to particular discrimination, with isolation and deprivation fueling high-risk behaviors. As one IDU said:

> We have been thrown out of the society due to addiction so now we have to depend only on drugs. To get the daily dose we will do anything, for example, sell either blood or sex. (37-year-old male IDU 37 years old, Karachi Pakistan)

In addition, IDUs face severe forms of discrimination from health care providers in the government-run facilities that are the only ones affordable for them. As one person put it:

> The doors of the private hospitals and clinics are closed for us, as we cannot afford to pay. We can go to government hospital but the hospital staff do not treat us respectfully so we avoid seeking care for general health problems. I have been to the civil hospital several times because of my asthma. The behavior of the hospital staff from the cleaner to the doctor was very rude. They were treating me like a second-class citizen. Without even listening to my whole problem, they handed over a list of medicines and asked me to buy them from the pharmacy. (36-years-old male IDU, Karachi, Pakistan)

IDUs report that they often prefer to self-medicate rather than seek care, even in cases of severe illness and infections, because of the disrespectful behavior of health care providers.

The following are three case studies that illustrate some of the issues described above.

Case 1

Mr. Zafer is a young IDU, 26 years old, residing with other IDUs on the streets of Saddar (a very busy marketplace in downtown Karachi). Unmarried, with an eighth-grade education, he started using drugs at the age of 13—first cigarettes and then *Charras* (homemade hashish). He says he started using drugs due to the influence of his friends. He used to spend 20-30 Pak Rupees[512] per day for two doses of *charras*. After some time, he started using Samadbond (a strong adhesive commonly available at stationery and hardware stores) and spending 40 rupees a day for three doses. He would get this money from his family, who were not aware of his drug habits.

Subsequently, Mr. Zafer switched to using heroin, heating it on a piece of tin (a lid of a can or similar) and inhaling the fumes. He spent 100 rupees per dose. For the last four years, Mr. Zafer has injected drugs, including heroin, antihistamines (Avil) and sedatives (Diazepam) intravenously.

Mr. Zafer listed the non-availability and high price of heroin as the primary reasons for switching to injecting from inhaling:

> Good-quality heroin is not available in the market anymore. There is low-quality heroin available at unaffordable prices. If we inject the low-quality heroin, its effects are immediate and prolonged. Most of the time, it becomes very difficult to get even low-quality heroin so we have to depend on Avil or other drugs. Now the dealers also change their locations frequently, due to the sudden raids by the police.

Currently, Mr. Zafar is injecting twice a day, one dose in the morning and one in the evening. Heroin costs him around Rs. 200-250 per dose and pharmaceutical drugs only cost Rs. 30–60. He earns this money by cleaning vehicles, and sometimes through petty crimes with other friends such as snatching purses or wallets at gunpoint.

Mr. Zafer has been arrested three times and jailed twice (for three months and six months) for possession of a small quantity of heroin. About his experiences in jail he said:

> They use very abusive language and physically tortured me every day because I did not have money to give them and nobody visited me in jail. Most of the time they kept me busy cleaning and gardening as a punishment. Police do not consider us as humans inside or outside of jail.

Asked about his HIV status, Mr. Zafer said:

> Two months back, I had a test done and I have been told that I am HIV positive. I planned to get the treatment for my addiction and the coordinator at the center suggested that I go for the HIV test before starting the drug treatment. Now after the positive result I cannot give it up because these drugs are my best friends. They keep me away from tensions.

Now Mr. Zafer's main concern is that he wants to get treatment. He hopes that the government will support him. He thinks he might have contracted the virus while he was in jail.

Case 2

Mr. Yaqoob, a 45-year-old married man and resident of Karachi, began using *charras* about 30 years ago for enjoyment. Along with that, he smoked two to four cigarettes a day, and it would cost 10-15 rupees. Then he started injecting cocaine in order to achieve a longer-lasting effect than cigarettes and *charras*. He spent 50 rupees per dose and worked as a gardener to make money. He is HIV positive, having contracted the virus through sharing contaminated syringes with his colleagues. "It has been four years since I was diagnosed with HIV and I have not gotten any treatment for it yet... I have lost my family," said Mr. Yaqoob.

Soon after his diagnosis, he received treatment (detoxification) for his addiction from a drug rehabilitation and treatment center. He hoped to start a new life and get HIV treatment. But after several months he rejoined his old group, as he said, "I joined my old street friends because nobody was ready to accept me, including my family. They were afraid that they might get infected from me."

Mr. Yaqoob has had several encounters with the police, and has been jailed five times. Asked about the availability of drugs in the jail, he said, "If you have money then

you can easily get the best quality charras and heroin in the jail, but if you don't, then you will be treated as a dog."

Expressing his main concern, Mr. Yaqoob said, "There is no shelter for me. I need a space to spend the rest of my life. I have not received any treatment for HIV yet and I am hoping that the government will provide treatment."

Case 3

Mr. Azam, a 33-year-old married man, is HIV positive. He says, "Two and half years ago I had my test done in a civil hospital and the test was positive. No treatment or services have been provided yet." Due to limited capacity and resources, the government is unable to provide basic HIV treatment and management services to all HIV-positive cases, and private care services are out of reach due to their high cost.

Currently, Mr. Azam is living at a rehabilitation center in Karachi that offers accommodation for a limited number of IDUs and runs drop-in centers. He is worried about his family. With eyes full of tears he said:

> It has been nine years for my marriage and I have a son and daughter. Initially, my wife supported me but after a year, she left me. My children are with her. They visit me once a month, and once they told me that to earn money, they fetch water in big containers (for households). There is no schooling for them and I am here. Quite often, I think I should commit suicide, as I cannot do anything for my children... I am useless and nobody cares about me.

Mr. Azam's story of substance use began at age ten with his first cigarette. Gradually, by the age of 15 he had graduated to *charras*. His preferred method was smoking or inhaling the fumes by heating the drugs on a piece of tinfoil. He would spend 100 rupees a day. After his marriage at the age of 24, he started injecting white crystal (made from cocaine) for an immediate reaction. This cost him Rs. 200-300 per day (for two doses). He said that he was caught by the police one time, but was freed after bribing the police with Rs 1,500.

Conclusion and recommendations

Pakistan has achieved the targets of supply reduction in the global war on drugs through aggressive antinarcotics policies and programmatic measures. The stringent policies that led to these advances in drug control, however, have also led to an increasing number of injection drug users and high rates of HIV transmission. Reduction in heroin supply and quality, and sharp increases in prices coupled with lack of demand reduction programs, has resulted in a shift to injection of synthetic drugs easily available from pharmacies. Other high-risk behaviors, such as unprotected sex, make generalization of the HIV epi-

demic likely. HIV prevention measures for IDUs, such as programs providing sterile needles and syringes, remain inaccessible to the majority of injectors.

Pakistan is at a critical juncture with regard to the increasing number of injection drug users and related HIV transmission. The epidemic is concentrated among IDUs, and is further aggravated by multiple factors, including lack of prevention and treatment services, discrimination, and criminalization.

To avoid a public health catastrophe in near future, there is an urgent need to address injection drug use and HIV through a holistic approach. First and foremost, Pakistan should scale up comprehensive harm reduction programs including needle exchange, condom distribution, education and counseling, free voluntary and confidential HIV testing, and rehabilitation services. The rehabilitation programs should involve family members and include skills building, which can help participants gain economic self-sufficiency and social integration after drug treatment. The government should provide free treatment and management services for HIV-positive cases. Specific prevention and voluntarily testing programs should also be available for children and the wives of IDUs.

Secondly, government workers that interact with people who use drugs, particularly health care and law enforcement personnel, should be sensitized to the needs and rights of IDUs. Higher authorities must no longer ignore abusive behavior of police toward IDUs (i.e. harassment, physical abuse, involuntarily HIV testing), and instead should adopt and promote a rights-based approach in dealing with IDUs. Public awareness efforts, including those involving religious leaders and institutions, are also needed in order to reduce stigma associated with injection drug use and HIV. As this study indicates, IDUs, including HIV-positive IDUs, understand the obstacles to care, and should be included in decision and policy discourses that affect them. Finally, national laws that violate human rights, such as those that allow the death penalty for drug possession, should be repealed.

Notes

462 The author is grateful to the research subjects for sharing their valuable experiences and agreeing to be photographed. She also offers her gratitude to the staff of the two drug-rehabilitation centers in Karachi for sharing their experiences and facilitating her access to the research subjects.

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513 78 Pak Rupees = 1 USD

Appendix

All the participants at the "Beyond 2008" Forum adopted the Declaration and Resolutions by consensus on 9 July, 2008

BEYOND 2008 DECLARATION

We, participants in the "Beyond 2008" International Non-Governmental Organizations (NGOs) Forum, representing the culmination of thirteen consultations in all nine regions of the world and involving over 500 NGOs from 116 countries and 65 international NGOs;

Acknowledge the long history of the Vienna Non-Governmental Organizations Committee on Narcotic Drugs (VNGOC) and its work to bring NGO contributions to United Nations (UN) drug policy events,

Note that NGOs are often the main providers of established and innovative services for those who use illicit drugs or misuse licit drugs and can thus be uniquely placed to make contact with and give voice to the individuals, families and communities impacted by drug use and drug policies for the purpose of promoting the development and implementation of more effective policies, programs and practices,

Acknowledge the human rights abuses against people who use drugs as an affected population and encourage Member States, the United Nations Office on Drugs and Crime (UNODC) and other relevant organisations to solicit the participation of all affected and stigmatised populations in identifying and responding to these human rights abuses, to illicit/harmful drug use[1] and to its adverse health, social and economic consequences,

Acknowledge that young people represent a significant proportion of those affected, both directly and indirectly by illicit/harmful drug use and drug policy, and *honour* the right of young people to be actively engaged in the formation and evaluation of all facets of global drug policy,

Recall the Political Declaration, the Guiding Principles of Drug Demand Reduction and the Measures to Enhance International Cooperation to Counter the World Drug Problem adopted by the United Nations General Assembly at its twentieth special session (UNGASS) devoted to countering the world drug problems together,

Welcome the Commission on Narcotic Drugs (CND) resolutions 49/2 and 51/4 on the need to recognize and encourage the efforts of civil society, including NGOs, in addressing problems associated with the use of illicit drugs and calling for their contribution to the UNGASS review and reflection process,

Are grateful for the support of our partner the UNODC and the generous financial and in kind support afforded by several Members States and non-governmental organizations to realize the Beyond 2008 consultations and Forum,

Acknowledge the United Nations drug control conventions, the flexibility afforded within these and the role and mandate of the CND,

[1] *Illicit drug use* is use contrary to the UN Conventions; *harmful drug use* is drug use which causes harm to individuals, families, communities or the environment; *illicit/harmful drug use* is drug use where action is necessary, including but not limited to prevention or intervention in the fields of criminal justice, education, health care, social support, treatment or rehabilitation

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RESOLUTION OBJECTIVE 1

TO HIGHLIGHT NGO ACHIEVEMENTS IN THE FIELD OF DRUG CONTROL, WITH EMPHASIS ON CONTRIBUTIONS TO THE 1998 UNGASS ACTION PLAN, IN AREAS SUCH AS POLICY, COMMUNITY ENGAGEMENT, PREVENTION, TREATMENT, REHABILITATION AND SOCIAL REINTEGRATION

Acknowledging the commitment made by Heads of States at the twentieth Special Session of the General Assembly to achieve significant and measurable results in the field of demand reduction, *inter alia,* by the year 2008, the commitment to report progress on achieving goals and targets by 2008 and the General Assembly request to the CND to analyze such reports,

Recalling also the Action Plan for the implementation of the Declaration on the Guiding Principles for Demand Reduction adopted by the General Assembly at its fifty-fourth session which states that civil society, including non-governmental organizations, can make an effective contribution to and should play an active role in addressing the world drug problems,

Noting the fundamental importance of prevention, including those efforts aimed at alcohol abuse and tobacco use, as important and complementary efforts to reduce illicit/harmful drug use,

Mindful that approaches to address the drug problem should be evidence based, supported by scientific data, culturally and socially sensitive, have a focus on the mitigation of both short term and long term harms and should be carried out with full respect for human rights and all fundamental freedoms,

Noting that data collection and monitoring over time is an essential basis for evaluation and the continuing development of relevant and cost effective policy and improved practice, and *welcoming* the initial efforts of UNODC and the Vienna NGO Committee to provide such instruments through the Biennial reports Questionnaire (BRQ) and the NGO Questionnaire,

Recognizing the important contributions made by NGOs since 1998, as reported through the NGO questionnaire and the Beyond 2008 regional consultations, including, *inter alia*:

i. the substantial increase in the number of NGOs addressing drug related problems, and in the number of staff and volunteers engaged with NGOs in this field
ii. the improved networking between NGOs facilitating their engagement with relevant governmental and regulatory bodies in the development and implementation of policy, strategy and best practices at national and international level
iii. the increasing quality and range of services and contributions provided by NGOs, from primary prevention, early intervention, outreach, peer outreach and low threshold services to treatment, rehabilitation and recovery services and the development of the capacity of those engaged in these services
iv. harm reduction, meaning efforts primarily to address and prevent the adverse health and social consequences of illicit/harmful drug use, including reducing HIV and other blood borne infections,
v. the increased attention to and advocacy for interventions which are culturally, socially, family, gender and age sensitive,

vi. their increased contributions to the research and evaluation literature,
vii. the involvement of all affected individuals and communities in the design and implementation of policy and practice.

Recalling that while the NGO Questionnaire and the Regional Consultations organized by Beyond 2008 identified the significant achievements of NGOs since the 1998 UNGASS it also identified areas which require further attention. To this end, the participants in the "Beyond 2008" International NGO Forum:

1. *Call upon* Member States:

    a. *to provide* sufficient resources, attention and priority in the development, implementation and monitoring of the full range of drug demand, harm reduction, treatment and social re-integration programs, as well as sustainable and comprehensive alternative development projects,
    b. *to reaffirm* their commitment to addressing illicit/harmful drug use as a public health issue requiring expanded responses similar to the commitment to international best practice on HIV and human rights approaches,
    c. *to enhance* their commitment to address public safety issues resulting from illicit/harmful drug use utilising evidence based responses and in accordance with human rights norms as part of a balanced approach,
    d. and NGOs *to offer* a plurality of services designed to make contact with people who use or have used drugs and their families in order to promote treatment, rehabilitation and social re-integration as well as improve their health and social well-being,
    e. and other funding bodies *to sustain and enhance* those services which through monitoring and evaluation activities are able to demonstrate effectiveness.

2. *Call* upon the CND to:

    a. *develop* a common standard against which demand, harm and supply reduction activities can be measured in terms of their efficacy and outcomes, including analysis of the unintended consequences of the drug control system,
    b. *ensure* that those who are most affected by drug use and drug policies are meaningfully and actively involved in the development of policies and programs,
    c. *evaluate* its own work and policies and identify ways in which its effectiveness and impact might be improved, including decision making by vote in accordance with the rules of procedure of ECOSOC and its functional commissions, as appropriate,
    d. *ensure* that its decisions are guided by the best and most relevant data and evidence, including data on psychological health, the transmission of blood borne infections and data on compliance with human rights norms.

3. *Call upon* UNODC to:

    a. *develop*, in partnership with the World Health Organization (WHO) and NGOs, a global program for the definition of standards and best practices in the delivery of services and assist Member States to develop and scale up these services in accordance with the nature of the drug problem in their territory,

b. *ensure* that the CND is provided with the broadest possible analysis of the available research and evaluation,
c. *develop* improved outcome monitoring and data collection tools to assist CND, Member States and NGOs to measure their effectiveness and achievements and assess the positive and negative impact of policy and practice, in the fields of supply, demand and harm reduction.

4. *Call upon* resource providers, governments and NGOs to include evaluation as a standard and required e*lement fo*r any project, and encourage them to ensure that evaluation is adequately funded, its reports published, where possible in an acknowledged journal, lodged with an appropriate library and disseminated as widely as possible, noting the importance of research and evaluation for the development of improved knowledge on what works and in what settings and for building workforce capacity.

5. *Support* continued ethical innovation of new approaches by NGOs, amongst others, using the full flexibility allowed for in the drug control conventions to build and develop the knowledge base, the workforce and our capacity to respond to reduce illicit/harmful drug use and its adverse health, social and economic consequences.

6. *Call upon* Member States, UNODC and the international and regional financial institutions to:

a. develop further long- term, sustainable, ecologically-sensitive, and fully inclusive alternative development programs in cooperation with civil society organizations including indigenous, peasant and farmer organizations and non-governmental organizations and to take into account traditional licit use, in line with Article 14 of the 1988 Convention,
b. *ensure*, before considering eradication measures, that peasants have access to viable and sustainable livelihoods so that interventions will be properly sequenced and coordinated.

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RESOLUTION – OBJECTIVE 2

TO REVIEW BEST PRACTICES RELATED TO COLLABORATION MECHANISMS AMONG NGOs, GOVERNMENTS AND UN AGENCIES IN VARIOUS FIELDS, AND TO PROPOSE NEW AND IMPROVED WAYS OF WORKING WITH THE UNODC AND CND

Acknowledging the efforts of the United Nations to improve its effectiveness by enhancing dialogue with non-governmental organizations and civil society,

Recalling the Political Declaration adopted by the General Assembly at its twentieth special session, devoted to countering the world drug problems, which recognized that action against the world drug problems was a common and shared responsibility requiring an integrated and balanced approach that involved civil society, including non-governmental organizations,

Recognizing and *respecting* the authority vested in the CND,

Appreciating the efforts of many UNODC country offices and national authorities in a number of countries to substantively involve NGOs in the development and implementation of drug policy and strategies,

Welcoming the formal consultative mechanisms which have been developed through which government, academic and practitioner participants have been able to explore issues of common policy interest in an open forum,

Noting that at present there are no systematic mechanisms available to consult with NGOs or with civil society generally to assist the CND or UNODC in developing their policy and programs whilst w*elcoming* the UNODC's efforts at increasing the engagement and participation of NGOs in drug control matters and the Executive Director's view that "drug issues are too important to be left to government alone",

Building on successful collaboration between NGOs, governments and UN agencies in the context of the HIV UNGASS and subsequent review of progress and on meaningful involvement of people living with HIV /AIDS in that process,

Noting that "Beyond 2008" was created to facilitate the input of NGOs into the review of the 1998 UNGASS on drugs and *encouraged* that it has provided a platform through which NGOs with diverse ideological positions have been able to meet and find substantial areas of common ground,

To this end, the participants in the "Beyond 2008" International NGO Forum:

1) *Exhort* all NGOs to come together in a spirit of shared responsibility, accountability and commitment to the betterment of all and to commit to a productive partnership among themselves, with their respective national governments and with key international institutions such as UNODC in order to advance the use of evidence informed, practical and on the ground experience to reduce illicit/harmful

2) *Call upon* the CND to:
   a) *review* consulting mechanisms which have been developed by other UN entities and establish mechanisms for both ongoing and recurring civil society participation, including affected and stigmatized populations, at the CND, including participation in plenary discussion and thematic debate to stimulate informed discussion and proposals for collective action,
   b) *commission* a review of the level of engagement and expenditure attributed to NGO activity by other UN entities and *consider and approve* proposals arising from such a review which can enhance the involvement and contribution of NGOs and further develop the role of the UNODC Civil Affairs Office.

3) *Call upon* Member States:
   a) to establish and support transparent and systematic mechanisms for engagement and consultation at a national level, including NGOs and those most affected by illicit/harmful drug use and drug policy, when developing policy, strategy and practice guidelines,
   b) to implement national policies and legislation that are supportive of civil society gatherings and discussions, remove barriers to the freedom of association and freedom of expression of those most affected by illicit/harmful drug use and drug policy and request that adequate time, space and resources are provided for such consultations,
   c) to support NGOs and seek their contributions on a more systematic basis by including them in matters related to the work of CND when appropriate,
   d) *to encourage and support* youth groups/initiatives aimed at reducing illicit/harmful drug use and its health, economic and social consequences,
   e) and regional groups *to create or use existing* international funding mechanisms, similar to the Global Fund to Fight AIDS, Tuberculosis and Malaria, to stimulate adequate investment in sustainable, evidence based and/or effective services to reduce illicit/harmful drug use and its adverse health, social and economic consequences.

4) *Call upon* UNODC to:
   a) *implement* the spirit and priorities of the General Assembly as it pertains to NGO engagement,
   b) work within the framework provided by the Joint UN Program on HIV/AIDS (UNAIDS) and in line with global political declarations, in collaboration with co-sponsors, to develop and strengthen civil society participation, including participation of affected and stigmatized populations, to match such involvement in other UN agencies and programs,
   c) *explore* means to establish national NGO focal points to promote two way communication, using as a model the structures established by UNAIDS,
   d) *promote* more regional meetings to share best practice,
   e) *support* thematic networks on specific drug-related issues, building on the work already, undertaken with regard to prevention and treatment, whether at regional, trans regional or global level,
   f) *take* a more active role in promoting a comprehensive package of interventions in the response to the transmission of blood-borne infections.

5) *Call upon* the International Narcotics Control Board (INCB) to:
   a) *broaden* the scope of key informants used in their analysis by systematically including NGOs and affected groups in that process,

b) *continue* meeting with representatives of civil society, including affected and stigmatized populations, when conducting in-country assessments in order to have the benefit of their input and incorporate their perspectives, as foreseen in Article 14 of the Single Convention,
c) *establish* a mechanism for NGOs to request clarification of statements made in the INCB Annual Report,
d) *publish* reports on substantive discussions and outcomes from their meeting with Governments and NGOs.

6) *Call for* the relationship between UNODC, CND and NGOs to be monitored and evaluated for the results achieved every two years by each party and through a joint monitoring, consultation and planning group, with meaningful NGO involvement and this evaluation should be results-based and reported to the CND as well as the UNAIDS Program Coordinating Board for further action.

All the participants at the "Beyond 2008" Forum adopted the Declaration and Resolutions by consensus on 9 July, 2008

RESOLUTION – OBJECTIVE 3

TO ADOPT A SERIES OF HIGH-ORDER PRINCIPLES, DRAWN FROM THE CONVENTIONS AND THEIR COMMENTARIES THAT WOULD BE TABLED WITH UNODC AND CND FOR THEIR CONSIDERATION AND SERVE AS A GUIDE FOR FUTURE DELIBERATIONS ON DRUG POLICY

Recognizing that the Charter of the United Nations, the founding document of the organization, enshrines the binding and primary commitment of signatories to health, human rights and fundamental freedoms,

Further noting that the present system of worldwide drug control is based on three international conventions: the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol; the 1971 Convention on Psychotropic Substances; and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, and that by 14 March 2008, 183 states were Parties to these three Conventions,

Underscoring that the drug control conventions sit within a broader framework of UN treaties and declarations including, *inter alia*, the Charter of the United Nations, the Universal Declaration on Human Rights, the Constitution of WHO, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the Declaration on the Rights of Indigenous People and the Declaration of Commitment on HIV/AIDS and that there should be complementarities between these international instruments and the respective UN bodies responsible for them,

Also underscoring that greater attention should be given to the health and public health aspects - in the widest sense - of drug policy, given the rapid spread of blood borne infections, including HIV and hepatitis, and the increasing evidence of co-occurring mental health and substance use disorders,

Noting that the need to take action on demand reduction is stressed in each of the three Conventions and *welcoming* the explicit efforts and decisions taken to address drug demand reduction including, inter alia, the Comprehensive Multidisciplinary Outline, the 1998 UNGASS Political Declaration, the Guiding Principles on Drug Demand Reduction and subsequent resolutions of the CND but *noting also* the discrepancy between the decisions taken and actual practice at national and international levels,

Drawing attention to the fact that the language of the Drug Control Conventions on supply control measures are mandatory on Parties while those related to demand reduction measures are not,

Concluding that despite significant and serious effort, demand and harm reduction activities continue to lag behind supply reduction at the national and international levels and that this is reflected in the balance of discussion at the CND and in the composition of national delegations to the Commission, as well as in UNODC budgets,

Acknowledging that the conventions require that "the Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment,

education, after-care, rehabilitation and social reintegration of the persons involved and shall coordinate their efforts to these ends" [2],

Recognizing that, consistent with the conventions, States Parties - either as an alternative to conviction or punishment or in addition to conviction or punishment for a drug related offence - may provide that the offender undergoes measures of treatment, education, after-care, rehabilitation and social reintegration, but *noting* that this provision is not adequately or appropriately implemented and *further noting* the technical advice available from UNODC on implementation,

Recalling that the "medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and the treatment of addiction, and that adequate provisions must be made to ensure the availability of narcotic drugs for such purposes" [3],

Underscoring that a majority of the "Beyond 2008" regional consultations reported that the controls required for narcotic and psychotropic drugs created an impediment to the availability of essential drugs for pain control as well as access to substances known to be effective for the treatment of drug dependence and access to HIV prevention, treatment, care and support and other health related services,

The participants in the "Beyond 2008" International NGO Forum:

1. *Call upon* the CND to:
   a. *re-emphasize* the importance of adhering to and fulfilling the obligations and commitments of international instruments, such as the human rights protection of the UN Charter, the Universal Declaration on Human Rights, the Comprehensive Multidisciplinary Outline, the Guiding Principles on Demand Reduction and resolutions agreed at the CND and *revise* the agenda of the annual session of the Commission to give greater time and priority to drug demand reduction and to the human rights consequences of drug control policies,
   b. *ensure* that reduction of illicit/harmful drug use and its adverse health, social and economic consequences, as characterized within the drug control conventions, are considered as challenges of equal importance to and as required as supply reduction activities,
   c. *create* Guiding Principles on Effective Treatment in consultation with relevant authorities such as the WHO, UNODC, UNAIDS, *et al* and relevant regional organizations as well as with service providers and those most affected by drug use and drug policy. These Guiding Principles should outline a common definition of effectiveness and structural conditions including *inter alia* policies, facilities, services and professional development aimed at achieving the greatest positive impact,
   d. *require* that the relevant authorities such as the INCB and UNODC, in line with their mandates, regularly address countries' performance against these instruments and guiding principles, and report annually to the Commission on the adoption and implementation of such instruments,
   e. *encourage* the availability of alternative sanctions and dispositions for drug related crimes.

[2] Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol, Article 38, para. 1
[3] Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol, Preamble, para. 2

2. *Call upon* Member States to:
   a. *ensure* that the composition of their delegation to the CND reflects the agenda and functions of the Commission, to facilitate good governance and policy guidance, with an increased focus on expertise related to the reduction of illicit/harmful drug use and its adverse health, social and economic consequences and human rights compliance,
   b. *support* the efforts being undertaken by WHO, in consultation with INCB and UNODC, to ensure that all drugs classified as essential medicines are widely and readily available to medical practitioners and their patients,
   c. *ensure* that more attention is given to the needs of those in closed custody settings so that they can gain access to the comprehensive range of interventions recommended by WHO, UNODC and UNAIDS.

3. *Call upon* the INCB to:
   a. *renew* its commitment to give equal attention to the supply and demand reduction elements of the Drug Control Conventions in their reports, challenging countries' poor performance and highlighting best practices and innovative approaches in both these elements with a view to fully exploring the existing latitude and flexibility of the Drug Control Conventions and ensure adequate supply of licit drugs to treat dependence and relieve pain,
   b. *regularly undertake* reviews of the application of criminal sanctions as a drug control measure, in consultation with other relevant bodies such as the UN High Commissioner on Human Rights (UNHCHR), the UN Human Rights Council (UNHRC) and UNODC, ensure full respect for the rights of prisoners who are drug dependent or in custody for drug related crimes, especially their rights to life and a fair trial and advise on the appropriateness of such sanctions commensurate to the actual offence and the opportunities for alternative sanctions.

4. *Call upon* UNODC to:
   a. *Ensure* greater knowledge and understanding by the CND of the reciprocal impact of decisions made and policies adopted by the Commission and related UN agencies such as UNAIDS, WHO, UN Economic, Social and Cultural Organization (UNESCO), etc.,
   b. *Seek* from Member States the resources and support to significantly enhance its analytical capacity and its ability to identify, collate and disseminate best practices in supply, demand and harm reduction and in human rights compliance,
   c. *Establish* a demand reduction mechanism equivalent to the Heads of National Law Enforcement Agencies (HONLEA) to provide it with improved technical guidance and information on policy and strategy and their practical application in the field.

5. *Call upon* NGOs to:
   a. *Work together* at appropriate levels (sub-national, national, regional or international) to develop and implement quality improvement criteria for their activities, drawing upon work which has already been undertaken in some countries and regions,
   b. *Increase* transparency and accountability by publishing annual reports including summary financial data, even if not required by national or local legislation.

6. *Call upon* CND, INCB, UNODC, Member states and NGOs to undertake regular policy and practice audits of their drug related activities, using information from a wide range of sources, including their target population, to identify areas for improvement.

A decade after governments worldwide pledged to achieve a "drug-free world," there is little evidence that the supply or demand of illicit drugs has been reduced. Instead, aggressive drug control policies have led to increased incarceration for minor offenses, human rights violations, and disease. This book examines the descent of the global war on drugs into a war on people who use drugs. From Puerto Rico to Phnom Penh, Manipur to Moscow, the scars of this war are carried on the bodies and minds of drug users, their families, and the health and service providers who work with them.

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